

DISCOURSE, CARE AND CONTROL: AN ETHNOGRAPHY OF
RESIDENTIAL AND NURSING HOME ELDER CARE WORK

by

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This thesis presents the notion that paid elder care work is often more involved with ordering individuals, than caring for them. It discusses this issue via ethnographic data about care assistant and nursing auxiliary work, which was collected in two elder care homes: Hazelford Lodge residential home and Bracken Court nursing home. The thesis uses care, control, and knowledge as the main themes for the discussion of work in both homes.

The first chapter sites the thesis within the context of the academic literature on the discourses of the body, the nature of care work and residential care. It focuses especially upon care work as body labour. Chapter two presents the ethnographic methodological approach of the thesis, in two sections. Firstly, the use of the Foucauldian notion of discourse is explained, and secondly, the research process and research relationships are explored through a reflexive account.

Chapters two and three present social, structural and spatial aspects of the two settings. They discuss the different ways in which the homes were organised, and that spaces were utilised and had different meanings, within the homes. Chapters four and five are based upon data from Hazelford Lodge residential home, and illustrate the care assistants' work as centred upon created order in the home, based upon the typification of residents and others.

Chapters six and seven explore the auxiliaries' work in Bracken Court and present three control issues as central to their jobs. Firstly the overt ordering of patients around spaces in the home. Secondly, the normalisation of individuals into patient, and objects, of body work. Thirdly, the auxiliaries' resistance to their role and status.

Chapter eight compares the work of the assistants and auxiliaries in terms of resident and patient construction, the nature of the two forms of work, their knowledge, and lastly, their constructions of place and status. The thesis argues that both groups of workers are involved in ordering bodies that they perceive to be problematic and degenerating. In Hazelford Lodge order and discipline is practised as care and in Bracken Court the auxiliaries use more overt forms of control, but both 'caring' and controlling are effective methods of creating order. By introducing notions of body labour and ordering, the thesis presents a unique critique of paid care.

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This thesis is dedicated to my nan, Ivy Lee, who is a hundred years old in June 1994.

AUTHORS' DECLARATION

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award.

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CHAPTER ONE: A CRITICAL REVIEW OF THE LITERATURE

INTRODUCTION TO THE THESIS

The aim of this thesis is to reveal, via ethnographic methods, the underlying discourse of women working in a nursing and a residential home who do the major contact work with residents and patients. The project is fundamentally about the nature of paid care work, the form it takes, its rationale and how this is enacted. In many ways the data questions the academic debates surrounding paid care and its relationship to concepts such as caring, control, containment, order, discipline and the nature of gendered care.

Both social understandings and the academic debate around care, paid or unpaid, have tended to view women as natural carers. Care work is presented as a set of positive, nurturing, altruistic, 'health-giving' acts, which are unproblematic for women. Although academics such as James (1989,28) note that maternal care can include negative acts to discipline, the abusive side of caring relationships remains largely hidden in academic research, (Thomas 1993,663) or represented as occasional cases of 'care gone wrong'. However, this thesis argues that abuse, control and manipulation are deeply embedded in the way paid care is organised and carried out in Britain; in the schemes of knowledge used to carry out care work.

Women's paid care work in institutions involves dealing with larger numbers of people than informal care within the domestic home. Institutions demand discipline in the form of the 'inmate' they seek to create and in the case of residential and nursing care the form of individual required is of 'resident' or 'patient'. Both care assistants in residential homes and nursing auxiliaries in nursing homes are grappling to control not only the environment but ageing, changing, bodies and difficult minds. These have to be controlled within the context of a potential passage from admission to residential care to admission into the nursing home. This is care work involving dependants who will almost certainly need more care input as time goes by.

In British society care and control have been themes which have dominated patterns of life in institutional care. However, care and control are not polar opposites in terms of disciplining mechanisms, nor points upon a continuum. They are inter alia two systems of creating discipline that are produced by certain discourses and encouraged by particular features of work. Thus, the notion of 'care work' is in some ways a misnomer which camouflages the hidden nature of the work which is about social order.

Notions of care work have become controversial with Graham (1991) and Ungerson (1990) criticising the constructions of care that they themselves and others used, during the late 1970's and the 1980's. (See Thomas, 1993, 648) There seems to be a gap between the experience and observation of care in residential settings and sociological understandings of the nature of care. This thesis applies an alternative approach to understanding care by identifying the schemes of knowledge involved in paid care and the origins of that knowledge. Care work in the two homes involved control, power, order and manipulation, both physical and emotional, of older people, as much as being about caring and the exploitation of women as carers.

The notion of the processing of individuals is used in the description of work within and between the two homes. These settings were chosen because of their interrelationship in the potential passage of older people from the home, admission to residential care and then to nursing care. Common-sense might suggest that residential homes provide basic supervisory care, and nursing homes nursing input for elderly people whose conditions need nursing surveillance. The thesis tries to present an interpretation of what kind of work is done in elder care homes and the nature of the underlying discourses used by care workers within the two types of home. Lastly, the thesis presents a comparison of some emergent themes from the data.

Ideas about sorting and ordering do not fit easily with traditional notions of care, but within this thesis care is presented as work and women not as 'natural carers' but as workers. In this way the thesis does not represent a destructive assault on paid caring but a critical analysis of notions that largely appear unassailable both socially and academically.

The Ageing Population

Demographic changes are producing an 'older' society. This general trend has been occurring since the early twentieth century, produced by a lower birth rate and greater survival of people into old age via medical developments and better standards of living and health. Despite this, during older age many people experience heightened rates of morbidity, the death of peers, negative stigmatisation by society, disability and social isolation. There is also a loss of social power and a marginalisation within general society. Most elderly people remain in their own homes cared for by informal carers or home support services; others will live in sheltered accommodation, a few will be homeless and a minority move into some form of residential care.

The growth of the 60+ age group and its predicted increase has fuelled fears about resources and care provision. The increase expected over the next twenty years is 9%. However, within this, the age group of 85+ is expected to grow by 62% (Arber and Ginn, 1991, 7). It is the disproportionate rate of growth of people who will be the oldest, most frail and most in need of care which has led to governmental and social fears of 'moral panic' proportion (Willcocks, 1987, 150). Indeed, the recent focus of community care policy can be interpreted as a reaction to the demographic changes and public fears, its central interest not being in care provision but care economics. The main fear seems to be over the ageing body; who will care for it and how much it will cost society. Thus, these issues also encompass a politics of the body.

The theme of community care has shadowed elderly care provision since the 1960's, culminating in the 1990 Community Care Act. However, the aim of care in the community has been characterised by some ambiguity between the political rhetoric and the actual practice embodied by policy. The public support for closure of large institutions has been double edged. There has been great support verbally for the closure and discouragement of public institutions for the mentally ill and insistence that the best care, as family based (Dalley, 1983, 21), exists within the community. With the elderly the concern has seemed to focus not on closure but on regulating the growing private sector and protecting the

older person. Within some arenas, private nursing and residential care have been viewed as forms of community care and as additional choices for the older person.

Yet monetary resources to fund community care have not been forthcoming and there has been an encouragement of private investment into elderly residential care. In the 1980's there was a massive expansion of residential care provision in the private sector, as Croft (1986,32) argues, the drive towards community care has,

"Signalled ... a massive expansion in inadequately regulated commercial institutions run for profit."

This was largely the result of benefit changes which meant that income support payments could cover the total of care home fees for elderly people receiving supplementary pensions (Arber and Ginn, 1991,189). During the same period home support services remained under-funded leaving residential care as virtually the only answer for poorer elderly people not coping on their own within the community. Residential care was effectively encouraged.

In the late 1980's there was a focus of media and public attention on abuses of elderly people within care homes, especially private ones. However, there have been some public campaigns more recently to keep local authority homes open. Public fears appear to have been aroused mainly by the private sector, the possibility of physical abuse and of unscrupulous proprietors. Abuse is a powerful discursive element in any context where workers are caring for people who, not only cannot defend themselves physically but may not have the ability to tell others, or even may not be believed due to the stereotype of senility as a feature of ageing. Abuse ranges from physical violence to enforced states of dependency and the denial of adult rights (Ungerson,1983,65-66; Walker,1983,109). But there appear to be problems in the social recognition and definition of abuses that arise out of caring acts. Also legislating for abuses that emerge from work routines or from practices, which are deeply embedded in society's ideologies of caring, is particularly difficult.

It is within this context of the social ambiguity of paid care work, the low social power of the elderly and the under researched 'private' sector of residential care that the data for this

thesis were collected. Ethnographic data were collected from Hazelford Lodge residential home and Bracken Court nursing home which are sited in the South West of England. In this area the residential care of the elderly is a lucrative business based around traditional seaside retreats. Therefore it is also a good place to study those who are paid to care for older people and the kind of knowledge they use to do that work.

In this chapter literature about the body, care work and residential settings is discussed. Firstly, section one discusses discourses of the body, especially of the older body. Section two presents a view of what we know about care homes, their rationale, physical structures and clients. Section three discusses paid care work in residential and nursing homes, the people who do it and the acts the work entails. The chapter highlights the nature of paid care as labour, which often involves working with the bodies and minds of individuals. For this work paid carers require a certain knowledge, which they practice upon those they care for and through which they create care.

Section One: Body Labour and Discourses of the Body

This thesis is specifically concerned with the body as the site of work but at the same time a product in itself to be presented to others. An inherent interest in body labour can be seen in two ways in previous sociological work. Firstly, some scholarship has been concerned with the regulation of the body. Thus, Goffman's 'face work' has much in common with research about the sexual presentation of the body, cosmetic surgery and management of chronic illness. Elias's (1978) work on the civilising process also focuses on changing social behaviours and the movement towards the regulation of physicality in the company of others, especially in the form of manners. Secondly, body labour is involved in people work and the creation of bodies as products of labour. Within this perspective we can site all of Foucault's work and much health and care research. Although the body is often not stated as central to the discussions, we are clearly in the realm of aspects of embodiment (Shilling, 1993, 23).

The second type of sociological work is the most relevant to this project. This thesis positions caring for bodies and people within the spatial entity of the residential and nursing home. It is very much about the representation of bodies as canvasses of others' aims and the work of creating those representations. Both care assistants and nursing auxiliaries are involved in caring for and controlling the body to have the same effect, to create a certain presentable form of order. Within this thesis the body becomes central, the analysis highlights body labour, movement, processing and order as essential in the organisation of older individuals in homes. There is a certain desperation with which both sets of paid care workers try and maintain an order within these settings of degeneration.

Understandings of the body and body work are pivotal to all forms of health care work. In the case of nursing provision for the elderly, the patient is often admitted with a problematic body and mind. Patients are people who have already been processed through other forms of care. The bodily states worked with may be said socially to represent degeneration. The nursing home's forte is primarily in bringing such states under control; physical, bodily control. The body may be thus be seen as both the work site and the product of work.

In residential care, the resident's body may not be so problematic. However, it is still imperative that the body of the individual represents the home's aims. The visibility and activity of the resident is necessary to illustrate the care the home offers. Both forms of home are in the business, quite literally, of the processing and presentation of ordered bodies. But the body is generally a problematic entity, for the medical practitioner, nurse, the sociologist and the lay person.

Discourses of the Body

In Western society, it is biomedical interpretations of the body that predominantly inform professional and lay understandings. Within the biomedical framework, the body becomes the stage for a variety of biological events. Under this model birth, maturation, reproduction, ageing and death are temporally ordered experiences structured by the forces of biology. In the social sciences the biomedical terminology and understanding of ageing

has been challenged, with the substitution of terms such as 'life course' for 'life cycle'. However, ageism still remains structured into bio-medical thought and practices.

Armstrong (1983,1-4), argues that the bio-medical understanding of the person as body evolved in the eighteenth century. During this period the gaze of the medic moved from being external to being internal. The internal movements of the body became mapped out via an anatomical atlas which came to represent the 'normal' working of the body. Prior to the medical mapping of the body there were a variety of other interpretations of how it worked. However, none of these managed to present their knowledge of the body as anything other than outward descriptions of symptoms. Biomedicine was able to establish the primacy of its map of the body, as a higher level of knowledge, based upon its access and ability to interpret sinister processes unseen to the untrained observer.

When the medical student confronts the real body she/he no longer interprets the anatomical map as a representation of the body, but the body represents the map. Therefore, the person becomes hidden behind physicality and treatment, a passive object of medical observations (Armstrong,1983,2). Yet in some ways, the map of the older body in its 'normal' condition is expected to be different from other bodies. The normal state of older bodies is typified at each reduced biomedical level as degenerating. Despite this construction, decline on an internal level does not necessarily mean pain or incapacity on an external one. But 'normal' older age is based around pathological states: the senile dementias, disability, immobility and disease. The dysfunctions and normal degenerations of the ageing body have constructed older age almost as a disease in itself.

Although the symptoms of old age are very similar to symptoms of illness suffered by other age groups, the treatment consequences are often very different. In a younger age group, the type of symptoms suffered by the elderly like incontinence or chronic pain, would be viewed as abnormal. But for the older patient the treatment for such symptoms may be less active, as these problems have been incorporated into the biomedical expectation of older age (Fennell et al,1988,39). At the same time, the elderly are the objects of increased medical monitoring and are high users of prescribed drugs which may have iatrogenic

effects. Increasing age is used as justification for increased medical surveillance, the elderly being the ideal patients in the 'panopticon' society, subdued, dependent and observable (Fennell et al,1988,5-6).

Gerontology is the only medical specialism, other than paediatrics, which deals with a chronological group rather than a set of diseases or certain organs of the body. But unlike paediatrics, it has a low status within medical labour, due to its associations with long term symptom control rather than curative medicine. The high status areas of medicine involve technologies and work which is considered highly skilled, such as surgery; these are also specialisms in which men predominate. The low status areas, such as elderly care, genito-urinary medicine and family planning, involve less technical work, attract less funding and employ higher percentages of women and immigrant doctors (Dobraszczyk,1989,43-5).

The difference between these specialisms can also be seen in terms of what the medical staff involved actually do with the body. Surgery and the glamorous areas of medicine involve physical intervention, breaching the external bodily divide. Low status areas involve ordering and monitoring the external areas of the body, they are non-surgical. Effectively, they demand a less invasive form of body work; also the bodies worked with in these specialisms: older people and women, may be considered as lower status socially.

The Nursing Construction of Bodies and Body Work

Lawler's (1991,29) innovative discussion of nursing and body work presents two ways in which nursing work is body work. Firstly, nurses are involved with the physical care and ordering of the bodies of people who could be considered, however temporarily, as dependent. Secondly, nurses are involved in aiding patients in experiencing their bodies through often difficult experiences: disease, disfigurement and the stages of dying. It is the mixture of these two roles which create what she terms 'somology', it is a new science of the care of the body and the person with body.

Somology is new because although body work has perhaps always been an important if not fundamental part of nursing work, the rhetoric has not always acknowledged it as such.

Nightingale nursing in its construction of a role for the nurse, did not emphasize the relationship of the nurse to the body. The nurse's 'science' was to be hygiene and ordering the environment, to facilitate medical work (Garmarnikow 1978, 103-116). Medicine was to be the dominant form of knowledge and Nightingale viewed the acceptance of this dominance as critical to the smooth running of the ward and hospital. Although the body was acknowledged to be part of the environment to be cleaned and disciplined, mention of body work in nursing texts, even up until quite recently, tended to be the candid and purely anatomical (Lawler, 1991, 38-43). Rather than being problematic, the body was obvious through its absence.

In the 1960s the professional bodies of nursing began to try to remove the notions of nursing as a 'vocation' and 'calling' and instead strove towards professionalism (Dingwall, 1977, 32). The new attributes of nursing were to be skills, training and independence from the traditional doctor/nurse professional relationship. This was to affect the way that nursing regarded the body, moving away from basic care and order, skills were to be built up in the highly technical areas but also in the area of the human sciences. The new nurse was taught sociology and social psychology during training; about grief processes, adaptation and adjustment to ward routines and psychological care.

Yet Williams (1978 42-3) argues that it was with the advent of this model of care that diagnostic medical language began to hide the patient as a person. Physical needs and conditions became re-labelled as 'manifesting' or 'aphasic' and so on, the patient becoming the sum of the condition of the body. This has led to the differentiation of the chronic and the acute, the latter being 'real nursing' where professional skills can be practiced, the former being the cases that nurses tend to hand over to lay care and unqualified occupations (Williams, 1978, 42-3). Thus, modern nursing finds itself torn between two objectives, the facilitation of the whole person, including psychological care and the integration of technology.

Elderly care within both the psychological and technical framework has been considered as 'basic' and marginal as such work involves facilitating the everyday needs of patients. This

is reflected in the view that undertaking elderly care work jeopardises the chance of working in higher status specialities and as nursing work it is marginalised in two ways. Firstly, elderly care work is viewed by the qualified as peripheral to modern nursing work and contemporary practices (See Melia,1987,134, Lawler,1991,30). Secondly, within elderly care settings, contact care work and basic nursing tasks are fielded out to the untrained, thus marginalising actual physical care as unimportant. Body work becomes associated with low status tasks and the untrained. Yet it is during such tasks that psychological care can take place; it seems there is a conflict between nursing rhetoric and psychological care and such work with the elderly. These patients become constructed as purely body labour tasks.

The Sociological Body

Until fairly recently much sociological writing has been characterised by its disembodied nature. Turner (1991,30) and Shilling (1993,19) have both drawn attention to sociology's disinterest and marginalisation of the body as purely a vehicle of higher concerns, especially in classical sociology. Turner (1991,7-8) argues that four major concerns prevented an embodied sociology. Firstly, classical sociology was concerned with the structure of industrialised societies, secondly upon social action, thirdly the mind was constructed as the impetus to action rather than bodily capabilities or restrictions. Lastly, there was a lack of interest in anthropological understandings of the social significance of the body. Sociology has been left with a focus on self/society not nature/society (Turner,1984,31). In many ways these concerns still affect the way sociology is proceeding and bodily sociologies are still in a marginal position to mainstream sociology.

Interactionist sociology has given a commentary on the body but it is treated as merely a backdrop for interactions and the mind. It is within feminist sociology, methodology and agendas that the body may be found. Turner (1991,20) notes that feminist research in particular has drawn attention to body politics with studies of the new reproductive technologies, pornography and women's bodily experiences as central to understanding sexism, exploitation and gender divisions. Shilling (1993,34) argues that the ageing body is becoming increasingly important in the sociology of health and medicine because of

extended age and the problematics of the degenerating body, especially in terms of treatment costs. But strangely, feminist agendas have not really addressed the feminised experience of older age with the same fervour as they have with younger embodied experiences such as birth, motherhood and middle age.

Yet, the experience of being older is overtly regulated and confined by the body, by the reality or fear of negative changes, decreased capacity, pain, mobility difficulties. Turner (1984,41) suggests a framework for an embodied sociology which might concentrate on,

"The reproduction and regulation of populations in time and space, and the restraint and representation of the body as a vehicle of the self."

Health care and social care work is involved with such issues on a daily basis. The work is essentially body labour because workers are either involved with the cleaning and physical manipulation of the body or have to manage and organise bodies into certain formations and places at certain times. In this way, body labour is centrally involved with ordering and controlling bodies.

Foucault and Controlling Bodies

Foucault's work focused upon the transgressing body as the subject and object of discourses and discursive power. Similarly, this thesis argues that discipline of the body is a component of all forms of care work, informal or paid and concentrates particularly on how women exercise discipline. The ageing body transgresses in particular ways which paid carers have to order and control, this involves the policing of the body and its creation as an object of the discourse. Foucault argues that bodies are idealised within discourse (see Dant,1991,125-126). In residential and nursing homes it could be postulated that the older body is targeted as a fragile and degenerating object that needs normalising and through this residents and patients are created. Those who do not conform to the normalised state are targetted and pushed towards a state of conformity.

Foucault viewed the body as constrained by the way that it was defined and mapped by frameworks of knowledge as Dant (1991,131) notes, for Foucault,

"It is the body that feels the effects of power."

This was illustrated in his work by the focus upon the growth and power of the medical profession and the new institutions of the eighteenth century. For example, in 'Discipline and Punish' (1977,4-5) Foucault describes, the horrific punishment of Damien the regicide and later the move away from this form of punishment of the body, towards incarceration and surveillance. In this way, power over the body moved from a direct form to a more distant type which also involved the mind.

Central to this understanding of social order was the ordering of the mind through the body, the 'panopticonisation' of society. A processing of the mind towards self discipline and regulation of the body could allow power over the individual to extend beyond the physical presence of another. Thus Foucault (1977,201) argues,

"Surveillance is permanent in its effects, even if it is discontinuous in its action: that the perfection of power should tend to render its actual exercise unnecessary."

For Foucault, Bentham's architectural design the 'panopticon' provided the mechanism by which surveillance and ordering could take place. Through the extension of panopticonism into regulation of the self, the body was not physically to experience surveillance and the external effects of power but a whole barrage of 'technologies of the self' (Turner,1991,14) eradicated the need for these. Thus, although power is found in its exercise, it is not always necessary. Modern society is characterised by self disciplines.

The ageing body is created in a particular social setting, which has definite features that may be said to feed into the workers' discourse. These settings are old peoples' homes, spaces in which older bodies are normalised out of the sight of the wider community. For workers in these places, there is a need to create normalised bodies in the format of residents and patients, they are the proof of care. But in residential and nursing homes the form of discipline is care itself and this is at least partially self maintained by the residents and patients. In this way the body and mind are implicated together in maintaining forms of discipline created by discourses.

Section Two: The Context of Care

The Principles Behind Elder Care Homes

Residential and nursing homes were set up to provide humane alternatives to the old workhouse/hospital style of provision for the elderly and a number of other vulnerable groups. The modern ideal is that they represent another choice to the elderly and carers, to allow supervised independence. After the National Assistance Act of 1948, authorities moved towards creating smaller residential provision for the old that was supposed to mirror the communal nature of the family (Townsend, 1964, 23-4). Purpose built homes were to mimic a home setting with fewer communal bedrooms and some provision for the residents' own belongings. Staff were supposed to be supportive rather than custodial, thus the Ministry of Health report of 1948-9 argued that staff and patient interaction and roles would change to;

"One(s) more nearly approaching that of an hotel manager and his guests" {cited in Townsend, 1966, 19).

However, residential provision has retained, especially for the elderly themselves, the image of the work house and of austere social control. Willcocks (1987, 146-7) notes that residential care settings do function as a way of limiting the demands of older people on the state. The marginality of the old is symbolised by the residence of some old people in homes and they therefore serve as a reminder to the old of what could happen to them.

Nursing and residential homes unsurprisingly advertise themselves in a language and style far removed from notions of separation or punishment. The official aims of residential and nursing homes are advertised in a commercial context and the official aims are open to public scrutiny. Homes do not advertise themselves as places that just house older people, there is the focus on an aim of providing care to an 'appropriate' level with trained staff. They are selling a form of order and indeed the ordered older person as a product, which is usually set within a familial framework. For example, Hazelford Lodge used the family in its advertisements as a standard,

"Hazelford provides care and a homely lifestyle that the management would be happy for their own relatives to enjoy."

Homes are presented within advertisements and brochures as places to live in, often with images of residents socialising and eating and drinking. There is little acknowledgement of death and dying. Hockey (1990,100) notes that the move into residential care is made more acceptable through metaphorical transformation. So the new admission becomes a 'resident' rather than inmate, the stress is on residing at the home, as opposed to dying. The daily work of staff revolves around maintaining the metaphor of life and obscuring death.

Bracken Court and Hazelford Lodge had two separate brochures but with the same words inside. They sold an image of retreat from the world, in which everything the resident or patient needed would be on hand and ordered by others. The brochures presented an order and structure, along with images of residents sitting in the respective lounges, visibly being entertained. In this way the two settings studied appeared publicly to project a convergence of aims. Through these official aims the depersonalising and de-powering nature of care was diminished and made acceptable. After all, the inherent effect of being cared for is to some extent a loss of personal control. Yet in advertisements and when Matron showed the potential client around, a healthy balance was constructed between care and personal control.

Aims have to be interpreted into the routine of care and this interpretation is based upon the objects to be cared for and their qualities. Residential homes generally deal with the lucid but socially needy. Dealing with such types of resident is problematic. These are often people who can care for themselves but perhaps seek the company of others or wish to escape the responsibility of cooking meals etc. They are also often capable of behaviours like complaining or refusing to comply. Hockey and James (1993,2) note that such behaviours are often infantilised as unimportant or "difficult" by staff in homes rather than viewed as rational attempts to maintain personhood. Such residents present particular discipline problems for care assistants, as control is needed over their minds.

The nursing home's official remit is to deal with medically problematic cases; the physically sick (chronic or acute), and the severely confused. This setting receives patients who have often already been selected as patient material by trained hospital nurses, doctors or social

or social workers and may have been disengaged from the general community for some time. Their bodily states may be distressing and also could be categorised as representing degeneration: incontinence, aggressive behaviour, depression, fear, immobility, pain etc. In such a state the body is socially threatening, the nursing home's forte is bringing such conditions under control; physical, bodily control.

Both residential and nursing homes are involved in the disciplining and organisation of older people. Care work is often exhibited through invasive procedures, routines and surveillance.

What are Elderly Care and Nursing Homes Like?

Communal residential housing for the elderly is provided by a variety of agencies in Britain. Willcocks (1987,148), using figures from 1983, argues that the economic basis of provision could be broadly categorised into three types. Private homes formed the largest sector at 56% whereas voluntary homes only constituted only 20% of the residential care home market. Larder et al (1986,7) in a survey of care settings for the elderly found that in England most provision of care was by the local and health authorities, with the provision of homes and wards respectively. Private residential provided the next largest number of beds, followed by voluntary provision and private nursing facilities.

However, more recent figures suggest that private sector care now provides more beds. For example between 1981 and 1991 there was a 13% national reduction in the number of elderly people living in local authority homes, whilst the number in private residential care more than doubled (Social Trends,1991,143). Recent figures obtained from Laing and Buisson (1994) indicate that in the case of national residential care home provision, approximately 17000 homes exist, of which only 2000 are local authority run. Laing and Buisson put the number of nursing homes at 5,000 nationally. This figure does not take into account the unregistered, unregulated homes which are operating illegally.

Willcocks (1987,148) notes that most research had been carried out in the public sector homes and although the last ten years has seen a massive private home expansion and a

decline in the public sector, we still have very little empirical research about them. Therefore, this section, although based on research about local authority homes, does not present an empirically based representation of private residential and nursing homes. Although we know something of their physical features, like the move towards more single rooms and privacy, the private sector remains hidden in sociological research.

Much of the critique of residential homes is based upon the critique of institutional regimes presented by the decarceration debate. 'Asylums' (Goffman, 1961), and Townsend's (1962) 'The Last Refuge', are probably the best known pieces of research within this framework, (although they were not the first to introduce the decarceration debate, for example, there was an NCCL report on mental handicap hospitals in 1951). Dalley (1983,24-8) argues that it was this attack that led to a focus on decarceration as the only option for the mentally ill and other groups. However, it also set the social agenda for the critique of the institutions concerned as extreme places of violence and personal degradation, and the abuses in elderly care homes became marginal to the debate.

The decarceration debate galvanised around mental health institutions and the effect of this has been twofold. Firstly, the debate centred around the easily recognisable abuses of the person that went on within them and the professional abuse of power of those involved. Secondly, this led to a focus on decarceration as the only answer to the problems of residential care which led to other alternatives being ignored (Dalley,1983,26). Other forms of residential care such as those with learning disabilities (Morris, 1969), and also children, (Kings, Raynes and Tizzard, 1971) and the elderly have always been in a different position from the mental health institutions, yet the issues around them have been framed by the notion of institutional care per se versus community care.

Residential and nursing elderly care has always been rather non-medicalised, divorced from ideas about treatment regimes and medical and nursing abuses. The large scale geriatric hospitals have not existed as extensively as mental hospitals and the regalia of restraint and control have not always been as visible. As a result elderly nursing and

residential provision has not been criticised in the same way by academics, by the general public or by the British media as the old style mental hospitals have been.

External Features, Internal Structures of Homes

In terms of general geographical positioning, care homes and nursing homes are not usually geographically set apart from the community, but tend to have features that make mixing with others outside quite difficult. Features perhaps inherited from more traditional forms of custodial care are large grounds and drive ways. For most residents with mobility problems such obstacles can be as effective as the more physically palpable barriers that Goffman (1961,15) identified as features of 'total institutions'. Thus, elderly care homes share with other institutions a certain social isolation. Hockey, (1985,38) comments about the nature and role of a residential home in the North East of England that,

"... The slow deterioration of members of an ambiguous social category will be managed within ... an institution set apart amidst lawned gardens at the periphery of the city."

Larder et al (1986,7) found that care homes were disproportionately positioned around the traditional seaside coastal regions. This tends also to be the case in the South West where many homes are not purpose built but are large converted domestic premises usually sited in the suburbs of seaside resorts.

The internal layout of homes is tending towards creating a home-like atmosphere. Commentators have noted a general trend towards a decrease in the number of people living in each home and the movement towards a replication of a largish family group (Townsend, 1964,23, Dalley, 1983, 26-27, Willcocks, 1987, 149). Individuals are being given more space in their rooms to customise the lifestyle with their own belongings and often have responsibility for the cleaning of their quarters or certain areas. Although as Willcocks, Peace and Kellaher (1987,1) note,

"The ideal of providing a 'homely setting is a genteel facade behind which institutional patterns, not domestic ones persist."

Behind the homely facade the phenomenon identified by Evers(1981,116) as 'warehousing' persists. For example, Hockey's (1990) ethnography of one local authority residential home found it institutionalised, with communal sleeping quarters that were regularly rearranged

when patients were showing signs of ill health. But the extent to which such 'warehousing' exists in different homes is unclear. In the private sector, it could be speculated that competition for clients and payment for services may mean that better conditions exist. Advertisements for homes would tend to suggest that single bedrooms are now the norm and generally residents and patients are allocated more private space than in the past.

The nursing home physical layout tends to be more hospital like in its structures. The type of patient cared for in this setting is more likely to suffer from the senile dementias or be physically ill, so the fittings of these homes reflect the different nature of care necessary, and the form of knowledge that legitimates that care. Sleeping arrangements are more likely to involve a shared room, even a ward type system. Those that live in the home become 'patients' and they are observed for symptoms of ill health, often by nursing auxiliaries who pass information onto nursing staff. In care homes, where even the Matron may not be a trained nurse, identification of illness may be more intuitively led. For example Hockey's (1990,120-121) care assistants used experiential knowledge of body colour and behaviour to perceive and preempt ill health.

In both settings decisions may be taken for the resident on the basis of what is best for them. Patients and residents are defined as childlike through the discourse of care, which may encapsulate notions of safety, resident/patient incompetence etc. For example, in nursing homes the regalia of traditional care tends to live on in the name of patient safety; bars on the sides of beds, locked doors, sharp utensils stored away. An infant-like type of responsibility is considered as the nature of the patients' abilities, thus dependency is a normal part of this setting. As noted above this may be a part of residential home life too but the staff in nursing homes may encounter less conflict than care assistants, who are working with more able people. In these ways, care and control are used to produce the regimes and the order in homes and care can be seen as a method to produce the same end as physical control and order.

Who Lives in Residential and Nursing Care?

Only a small percentage of the elderly people live in communal establishments such as long stay hospitals, public and private nursing and residential care. But the exact figures are difficult to ascertain, especially as a large number of illegal homes are probably operating in Britain. Laing and Buisson (1994,66) note the typical elder care customer profile as female, very frail, with a number of disabilities, aged 75+, without a partner or spouse who could provide care services and who often have had their admission organised by others, very often a daughter or daughter in law.

Elderly care homes are designed to provide 'care' to relatively physically able people who can be said to have problems caring for themselves in social terms. On the whole residents are lucid, fairly able and mobile and are not considered acutely sick, although they may suffer from chronic illness, as many elderly people do, this does not generally need special management or care. The physical and mental ability of care home clients leads to a flexibility and autonomy not usually found in institutionalised settings dealing with the more seriously impaired, as nursing homes do. The ability of the residents also allows a more active timetable of events to be arranged by management and staff.

Nursing homes provide care for clients with conditions which are considered to need regular nursing management and may also need regular medical input. Thus, they tend to house the great majority of senile and physically disabled elderly housed in communal settings. Research suggests that despite the popular interchangeable social use of the terms nursing home, residential home and hospital when referring to elderly care provision, they actually form a continuum of services that cater for a wide variety of levels of need (Victor, 1991,147).

However, there is still some debate around the distinction between care provided in residential and nursing homes for both elderly and people with learning disabilities. (See Ovenstone and Bean,1981, Morris, 1969,257) There is also concern about whether residents need care at all. The difference between those inside and outside of institutions who are impaired in some way appears to be whether there are informal carers to provide

support within the community rather than, for example, the physical state of the body (Arber and Ginn,1991,155).

Between private and public provision there are also some differences. Local authority provision tends to cater for more disabled residents, private homes largely housing the more fit and able. Although as Victor (1987,147-8) argues, it is unclear whether this difference could be explained by the new, fairly recent, rapid growth of private care which gives it, at present, a younger and fitter population than the local authority counterparts. It seems plausible that private care homes do have far more choice over who they admit. Also state provision has been linked to crisis provision and many such crises will be linked to the advent of illnesses and disability.

At the time of the data collection, admission to residential care in the public sector was generally taken to be on the grounds of need. Private homes catered for two types of clients. Firstly, those able to pay for themselves or who were paid for by relatives, secondly, those supported by Department of Social Security payments. Thus, in theory suitability for admission into private care at the time of the data collection may have been affected by ability to pay and possibly individual resident choice. However, admission to residential care often occurs at crisis points, rather than having been a planned move. Challis and Bartlett (cited in Victor, 1987,296-7) found that only 5% of elderly people being admitted to homes in Bath had been admitted by their own arrangement. The rest had the move arranged by relatives (55%) and somewhat surprisingly 40% were organised by professionals, mainly general practitioners. So most elderly people are not in a position to make a choice of home, they are allocated one at a point of crisis.

Arber and Ginn (1991,154) provide an analysis of later life as depicted by the 1981 census which shows that of all elderly people aged 65+ only 2.5% of men and 4.6% of women live in institutions. However, the nature of these home populations becomes clearer with a breakdown of age. Homes cater for 1% of men and women in their late sixties, this rises to 12% of men and 20% of women over 85 years.(Arber and Ginn,1991,115) Similarly Laing and Buisson (1994,66) using more recent survey data from their own market survey of

homes argue that of the 85+ age group 42% reside in nursing homes and 41% in residential care. They also argue that figures from the 1991 census show that 89% of those aged sixty five in care homes are single, widowed or divorced. These people tend not to have others who could possibly care for them outside care homes.

Thus, as age increases, so does the chance of institutionalisation with elderly women more likely to be institutionalised across all ages than men. On a national scale nursing and residential homes are largely inhabited by very old frail women. These institutions also employ mainly women care workers, so the nature of these communities can be tentatively expressed as being 'feminized'.

Prior to the April 1993 changes and at present, it might be assumed that homes can offer a higher level of care for the elderly than the community. Part of this assumption is based upon the notion that homes offer a structure and routine for the residents' or patients' life.

Time, Organisation and Regimes

In residential and nursing homes, the management of time and space is central to work. Residents and patients have to be seen to be living in the home and part of this involves them being in certain spaces at certain times. The social sciences have analysed time within their own paradigm of careers, trajectories and status passages. The study of time has been a major focus of interest in the study of medical settings and used particularly by interactionists. (Sudnow,1967, Glaser and Strauss,1967,1972, Roth,1963, Hazan 1980, Gustafsson, 1972).

In institutions, the ability of staff to order time for others could be seen as a form of power, which involves restricting and ordering peoples lives. Roth (1963,1) notes that to be ill is to 'lose' time in treatment, there is a very real sense of something intangible denied. Goffman (1961,67) argues that it is only within institutions that time itself becomes a punishment. As such, inmates seek to 'kill' time and break the monotony of routinisation via any option open to them. Around the possession of time inmates devise elaborate plans to

use institutional therapeutic or rehabilitation time not for self change but to kill their own boredom.

Roth's (1963) work noted the importance of time management and organisation to individuals in the patient role, even if their understanding of time is different from those around them. Thus, the long drawn out career of the tuberculosis case is reconstructed via the patient into a set of ordered passages, annotated with "benchmarks" (Roth,1963,3-7). These may involve certain treatments and a step forward or backward along the patient career depending upon the outcome. From this, patients can judge themselves against others and against an 'average patients' temporal structure. The goal of the patient being to organise the time prior to being discharged.

Movement into residential care is a major status passage for the elderly, symbolising loss of independence and being the last physical break from general society. Due to this, residents' careers may be somewhat different from those in other forms of institution who have some chance of getting out, and within which there may be some form of positive change attached to leaving. Roth (1963,12) argues that nursing home residents cannot be said to have careers, as their situation is so dead-end there is no moving forward or backward. However, Gustafsson (1972,227), in response to Roth, argues that even within the scenario of institutionalised life in nursing homes, there is room for negotiation of passages between staff and patients, and their actual career can be broken into passages as they approach death. However, Gustafsson does not suggest how the acutely ill or senile patient in such a setting might do this.

Movement and change are linked to the sociological conceptualisation of time. In elderly residential care, Glaser and Strauss (1968,196,61) argue that;

"These institutions have a kind of slow-moving timeless quality; after all they are set up to care for patients who may linger for months or years."

Others portray movement and time as changing, slow at some points yet speeding up during illness. Hockey and James (1993,16) argue that movement through elderly residential care can be seen in two ways. There is an initial movement *into* the centre of home life but later

with ill health there is both a general *downward* spiral and also a movement *out* from the centre of home life to the periphery and finally out of the building.

Although it can be seen as slow, life in homes is ordered around a rigid daily routine that involves care tasks and meals. Evers (1981,116) links time and the routine in geriatric wards to a loss of individuality which often is made worse by discontinuities in care and lack of communication by staff.

"The order of putting to bed usually took no account of the order of getting up, thus those that were up last night well find themselves the first back up, perhaps, no more than two or three hours."

Routine often involves the physical movement of people or perhaps more importantly, their bodies, around the space of homes. It is this appropriate movement and placing of the individuals which represents care properly done.

The structuring of time by tasks is taken to be central in the maintenance of order. Tasks meticulously done are also proof that care is going on;

"Staff expect trouble if a lack of care - lack of routine and order - become apparent" (Willcocks, Peace and Kellaheer,1987,59).

This is similar to the traditional nursing belief that order of the environment is the key to facilitating health. (Garmarnikow,1978,93,105) There is also a general lay belief that certain groups of people (usually those considered dependents like children and those with disabilities) need order imposed and maintained in their lives via the application of external discipline.

Time organisation around chores and routine may also be seen as a management strategy to protect workers. Bates (1991,232) noted that young women working in residential care felt they were often kept busy doing unnecessary tasks when the general care was over. She argues that this may have been a management strategy to prevent staff getting attached to residents or thinking about the work because the residents were passing through fairly regularly. The prioritising of physical tasks above psychological ones is also an issue in nursing care although this has been linked to time constraints. Although in theory and

rhetoric, holistic care is viewed as important in nursing, nurses still concentrate on physical tasks as real work, often because of time and routine constraints (see Melia,1987,19,21-22).

The title of Willcocks, Peace and Kellahe's (1987) book 'Private lives in Public Places' draws attention to the space problematics in residential care settings. Homes combine the public and the private domain and also are places of work for paid carers but the issue of space and workers in these homes has not been attended to by literature on homes. Space has usually been studied in terms of residents and territorialness over rooms and objects. Research has focused on gender differences in spatial needs and ownership patterns of residents. (For example, see Willcocks 1987,151 and Evers 1981,110 for material on women residents, space and chores).

One of the few pieces of work which acknowledged workers' use of space in homes is Hockey's (1990,115-123) study of one residential home and the management and organisation of death and dying. Part of the management of death involved the categorisation of residents into the 'fit' and the 'frail'. The frail, who were viewed as close to dying, were spatially ordered along the bottom corridor where they could be easily attended to and easily removed as bodies. In this way space organisation allowed staff some control.

Proximity is clearly important in mapping out social relations and social status in many forms of work. Goffman (1959) was the first to draw attention to the spatial concepts of the front stage and back stage. It relies on the idea of individuals acting for audiences within settings and of the backstage as a place where the actors can "let their hair down" and relax behaviours. This seems to ignore the notion that areas out of sight of a main focus area in a setting may have a strict etiquette of its own, perhaps an opposing etiquette but as ordered as the main focus. Goffman seems to suggest that the areas other than those of central focus are characterised by a general breakdown or exhibition of opposing behaviours to those in central view.

"A place, relative to a given performance, where the impression fostered by the performance is knowingly contradicted as a matter of course." (1959,114)

This is not useful when understanding worker behaviour as structured within a type of discourse. Hidden behaviour may be organised around a direct contradiction of front behaviours or may be governed by a different aspect of the discourse or group rules.

Goffman's interactionist focus leads to a depiction of front and back areas as very similar in function in a number of places: hotels, health settings, institutions, even domestic homes. There is no notion of motive, aim of setting or differentiation between rationale. The backstage for care assistants is qualitatively different from the backstage faced by nursing auxiliaries. In some ways guarding the backstage may be more important for them as the level of degeneration and bodily disarray in areas such as bedrooms is greater.

It seems that a more critical approach is needed which attends to the use and abuse of time and space and their interrelationship within homes. For both nursing auxiliaries and care assistants movement of individuals around the routine and spaces is central to work and is a difficult job. For the former, space ownership becomes problematic when individuals cease to be clearly able to arrange their own possessions or bodies. For the latter, capable people have to be persuaded around a general routine and their individual needs have somehow to be met within it. The image given of time and space within homes at present does not locate them as central to constructing order, when clearly this is very important.

Section Three: Care Home Staff and the Nature of Care Work

Residential care work as we now know it was created by the 1948 National Assistance Act in which local authorities were obligated to provide for,

"Those in need of care and attention not otherwise available", (National Assistance Act 1948, part 3, Section 21).

From the beginning, its remit was based within "care and attention" rather than a medical or nursing definition. Residential homes still do not need to have trained nurses either in management or general employment in the home and they are assessed for suitability by Social Services.

At the time of the data collection, in the case of nursing homes the person in charge has to be a trained nurse and assessment for suitability is undertaken by the Health Authority. Nursing staff in nursing homes includes Registered Nurses, Enrolled Nurses, and untrained nursing auxiliaries, but the nursing auxiliary's role is physical care rather than technical nursing work. There may also be a number of other workers such as cleaners, laundry workers and handy people. The nursing home tends to be more hierarchical with tasks strictly divided, whereas in residential work, care assistants often undertake a number of domestic chores and there may only be one level of worker covering a number of different roles. In other homes roles may be interchangeable in times of staff absence.

Care assistants and nursing auxiliaries share characteristics in that they are usually female and are formally untrained in adult care work, although they may have cared informally for adults and/or children and have worked in other residential or nursing homes. The pay is poor, turnover is high and union membership is low, especially in private care. Therefore, as workers, paid carers are largely unprotected from their employers (Clough,1986,88-89). There also may be some movement between care assistant, nursing auxiliary and other paid care jobs.

In the last decade there has been a tendency for owners to recruit young trainees as care workers, via the youth training scheme and more recently via various placements for National Vocational Qualifications in care. Bate's (1991,230) study of care women on the Youth Training Scheme found that elderly care work was not their first choice of employment. They tended to drift into care work when other possibilities, such as shop work and hairdressing, were closed to them. The initial reaction to the job was not one of altruism and motivation for training but of repugnance at doing a dirty job. However, questionnaire data from residential elderly care workers has tended to find that many state they want to work with the elderly and express positive aspects to the job (see for example, Social Care Association and Help the Aged,1992,8). There may be a number of reasons for this discrepancy but the expectations of care workers and how women are expected to react to the role of carer may be of importance.

The new National Vocational Qualification scheme seeks to provide all scheme leavers with a qualification and also offers the same practical courses for those 'on the job'. There has been some debate, though, about the standards of the bottom levels which some argue are low, representing few actual skills. However, levels one and two in care within the scheme will be compulsory training for all new paid elderly care workers within five years. In theory the stratified levels of the qualifications mean that a care worker may be studying for a lower level award, focused mainly on practical skills, at the same time as a senior care worker or Matron may be doing a higher level which involves material from the social sciences and social work sources. However, it is unclear whether homes are willing to pay for any workers to undertake the higher levels.

The possibility of the differing levels of training may mean that staff may be being given different forms of knowledge about the care of the elderly at the same time. Although research on the combining of the student and worker role in health care suggests that theoretical knowledge is often based on an ideal view of health work: in practice difficult circumstances and financial, temporal and social factors constrain work (Melia, 1989, Mackay, 1989, Dingwall, 1977, Abbott and Sapsford 1990, Highland 1990). Thus training may not necessarily translate into changes in practice or schemes of knowledge.

Care work recruits a lot of older women returning to work after raising families and who often have few formal qualifications. Home owners often view care work as women's employment, with chores similar to running a home and caring for children. It is work that women are socially seen as 'naturally' good at, in the same way noted by Mackay (1989) that nursing until very recently was considered 'natural' work for women and an aspect of femininity driven by vocation rather than professionalism. Being a good nurse was bound up with being a good woman. (Mackay, 1989, 155) The implementation of Project 2000 sought to change this image and in a sense the changes in care home work are an attempt to free it from its low female status and unqualified image too. The social categorisation of care as women's work also has the added bonus for employers that women workers, especially the young and those who are older and untrained, are cheap to employ for work which is quite hard physical and emotional labour.

What is Care?

Care labour has proved problematic to define. Graham (1983,23) notes that care in capitalist society is viewed as non-productive women's labour and as 'just' care whereas men's work is 'doing' things. Academics have tried to analyse it in terms of being labour (sociology, social policy) and as love (psychology). However even the former accounts have been bound up with notions of women as 'natural carers' despite their criticism of psychological notions of femininity as bound up with undertaking care work. Thus, the construction of paid care as work is still entangled with ideas of gender, informal care and family roles.

There also seems a problem for sociology and social policy in the focus on searching for a generalised notion of care as an umbrella concept for both paid and informal care. Ungerson (1990,12) notes that part of the problem of such a generalised idea of care is that 'caring for' people is different from 'caring about' them but that the actual terms are interchangeably used within society. She argues further that Land and Rose's term "compulsory altruism" is too generalised for application to the case of care. Ungerson (1990,14-16) argues, using Waerness's framework of care work, that a new understanding of care needs to move away from the traditional divisions between,

"Paid, formal, caring and unpaid, informal, unpaid, informal caring." (Ungerson,1991,15)

Within this, notions of public and private care are based upon the power relationships between carer and recipient and the individual basis of the care, whether paid for or not.

However, even this framework appears to make basic assumptions about care relationships. In centring mainly on the power relationship between carer and recipient it seems to suggest that we have a strong understanding about such power relationships and the criteria that affect it. However, very little is known about the basis of care. Firstly, informal care has not been observed in action in the same way more formal types of care have because of its very private nature. Secondly, even with the data that we have from care work, power has not been analysed as a problematic phenomenon.

There seems to be some neglect of the notion that caring acts can in themselves be controlling. Although carers are themselves exploited through poor conditions, lack of training and resources, there may be some exploitation on the part of the workers of emotional labour and relationships to order care more smoothly. This raises the issue of care as control, which may be useful both in informal and formal settings. Understanding power relations and their use for both participants may usefully add to understandings of care and reveal the overlap between its differing forms. Also if care is about inter carer/recipient relationships, in situations where the recipient is actively created but not recognised as an individual, it may be useful to discuss some forms of 'care' as body management or body work. Generally notions of care, caring and work need to be empirically studied, unpackaged and critically analysed.

This thesis considers paid care work as work. The study of paid care must be sited within the contemporary work context of an economic climate where getting work is difficult. Possibly women get care jobs because employers want women for these part-time, low-paid dirty jobs. But care work is often not their ideal occupation. Doing care work is often a case of economic necessity and lack of other choices. Paid care is generally part-time, locally-based work, more readily available than other jobs due to high turnover and can be fitted around child care arrangements more easily. Leaving care work is also problematic due to the notion that it is 'skill-less' often leading to a movement from one care job to another.

Despite research about nurses and women caring in the semi-professions, most paid carers are hidden in academic literature. Paid women carers work as untrained aides, care assistants/helpers, home helps etc. under the direction of other trained women workers. This group of women workers will possibly increase as professions such as nursing move towards a more supervisory role. Low status workers do most of the bodily care work involved in health care, yet it is still trained nurses who are seen as those who undertake such dirty low status work. Thus, the contemporary experience of paid care work as invisible is reflected in their absence within sociological literature. Being a 'caring' person

does not adequately or accurately explain why many women undertake care work or give an understanding of how they do it.

The Development of Nursing and Care Work

The nursing discourse was developed in relation to two other forms of thought, firstly nursing was created in relation to lay understandings and forms of care as superior to them. Secondly, it was created as subordinate to medical work. Nursing distinguished itself from lay carers by portraying them as immoral, uncaring, undisciplined and unscientific (Williams,1980,43). Lay workers defied doctors in considering their knowledge to extend into medicine, in which they were untrained, therefore they represented both disorder and disobedience. The nurses' science was to be the ordering of the environment to facilitate medical labour, (Garmarnikow,1978,93,105). So although nursing gained its legitimacy from medicine it was to be subordinate. Garmarnikow (1978) argues that although the reforms of nursing formalised caring skills they still defined them as lesser.

The new trained nurse was to embody opposite attributes to the untrained worker. The Nightingale nurse was developed around Victorian feminine virtues, the only necessary qualification was her moral status in being a 'good' woman. The 'good' woman was a natural nurse with the maternal attributes of altruism, self sacrifice and caring; she also subordinated herself to men (Garmarnikow,1978,103-116). In this way the creation of nursing centred upon the derision of lay women.

So, rather than 'care' or a science of the body, one could say that nursing's roots stemmed from 'cleaning' and ordering the ward to facilitate higher status medical work. At the same time as accepting the superiority of medicine and creating its own science of the environment, nursing actively excluded lay forms of care, in the sense of negatively defining lay women carers and excluding them via recruitment. Witz's (1992,48-51) notion of 'dual closure strategies' is useful in understanding the way nursing sought to create a place for itself in health work and

"The manner in which women may contest demarcation."

Witz (1992,48) draws attention to the difference between inclusionary and dual closure strategies in nursing. Inclusionary strategies involve resistance to the dominant group above through usurpation in an attempt to be included within that structure. Dual closure strategies do not involve an attempt to join the group above (in this case medicine) and rather than usurpation of those above, they involve resistance to the groups above and the application of power against them. But at the same time there is an exercise of power downwards to exclude others. In nursing this allowed a certain monopoly over legitimate nursing care work and powers over recruitment.

In the 1960's nursing began to turn its back on the ideas of nursing modelled on 'vocation' and 'calling' and instead strove towards professionalism (Dingwall,1977,32). The new attributes of nursing were to be skills, training and independence from the control of doctors. Skills were to be built up in highly technical areas. Williams (1978 42-3) argues that it was with the advent of this model of care that the patient began to lose out and diagnostic medical language began to hide the patient as a person. Ironically, at the same time nursing was shifting emphasis in training, onto the social sciences and especially psychological accounts of the patient, and, in rhetoric, in favour of holistic and psychological forms of care.

Nursing was developed around an elaborated parenting model of care which was bound up with issues of care and control. Thus, it is the nurse who relieves pain and cares for the body but also who has more contact with patients than doctors and the most disciplining role. Daly (cited in Ashley,1980,17) notes that it is the nurse who,

"Functions as the proximate and visible agent of painful and destructive treatment."

It is nurses who administer injections and painful treatments, withhold medication and carry out doctors' instructions. The role of care assistants and auxiliaries appears to take over the more humane aspects which used to be more part of nursing work: touching bodies, washing, dressing and possibly talking. The work that these workers do is discussed next through three components, the physical, the emotional and the dirty.

Describing The Work of Care Assistants and Nursing Auxiliaries: Care As Physical Labour

The understanding of paid care work as physical labour is probably grounded in research of domestic labour. Oakley's (1974) work is the most well known research that explained domestic work in terms of chores and compared it to alienating forms of factory and assembly line labour. Physical work in the residential home revolves around working with things, material objects to create the home setting which is suitable for the residents. The nature of the environment created is based on the perceived needs and abilities of the residents. Chores include: washing and repairing clothes, cooking, entertaining residents, cleaning, organising trips out, giving out drugs; along with some bodily care depending on the number of residents with those needs.

Graham (1985) describes "providing for health" as the main role of women in the domestic home. This, as well as involving cleanliness, cooking and providing for material needs, also included a vague notion of providing emotional support and negotiating with the outside for those within the family. This is useful in terms of discussing care assistants whose broad role may include work with 'others' outside those living at the home (relatives, visitors, professionals etc.) and negotiating for their needs.

However, in the case of paid care work the case could be made that it is far heavier than housework and more stressful in some ways. Rather than getting one relative up in the morning the paid carer in residential or nursing care has responsibility for a number of different people and chores. Unlike the informal carer or domestic labourer they also may not have autonomy over their work and may not be able to order breaks or choose to eat etc.

Physical care work in residential and nursing homes, as with nursing work in hospitals, is constrained by considerable time constraints. In nursing and residential settings getting through the physical work may be made harder by a lack of care assistant or auxiliary knowledge about how to undertake chores quickly or safely. Lower ranking staff may not have knowledge of how to lift, of how diseases are spread or of the protective clothing and aides they can use. Thus, work is not only physically heavy but dangerous.

The construction of paid care work as the extension of work in the domestic home has lost sight of the essential differences between the domestic and the public sphere as work places. Thus, when Graham (1983,26), argues that care work as a person centred task is;

"Experienced as an unspecific and unspecified kind of labour, the contours of which shift constantly,"

she is talking ostensibly about the experience of caring informally, whereas institutional paid personal care work with the elderly is highly structured and routinised. The recipient of paid care is often expected to fit into the system rather than the care being organised around them.

When care is constrained by rigid time-organisation, abuses can occur as part of getting the job done, and these are not necessarily considered by staff to be abusive practices, they are just part of work. Time pressures in nursing research have been linked to high levels of chore orientation to the detriment of other areas of care such as talk and comforting (Melia,1990,26-27,30-38, Mackay 1989,26-27). Similarly, the effects of time constraints in institutional elderly care have been discussed as having two effects. Firstly, routines themselves can become a form of mistreatment and lead to depersonalisation and secondly, workers may engage in punishing behaviours. Bates (1991,232) notes practices such as ramming wheelchairs into residents legs to make them walk, as forms of abuse which are everyday strategies of control in residential care. Stannard (1978) in his famous study of care aides in a nursing home in the United States, describes violent abuses of the person. He implicates lack of time, low status and the lack of training of staff as factors predisposing punishment of patients.

One way in which paid and unpaid care are similar is the model of care applied, in both cases this is a parental and mainly mothering model, (Graham, 1983, Willcocks et al, 1987) which involves a relationship of dependency between the carer and the cared for and often also the cared for and the state. Long term dependency for the elderly often involves a lot of personal care tasks for which the only model of care that many carers have experienced is the mothering model. Hockey and James (1993,9-18) go further to draw attention to the social metaphor of old age as a second childhood and with it bringing notions of the need for dependency and incapability. This metaphor is useful for carers as it gives a way of

rationalising and coping with intimate care tasks and with clearing up polluting bodily waste products. Infantisation as part of the discourse of care legitimates the relationship as 'natural', unthreatening in its similarity to the tasks of parenting.

Care As Emotional Labour

Emotional labour was originally constructed as part of women's work in the domestic sphere, as in Graham's (1985) notion of women as negotiators within the home and providers of health via emotional support. However, innovative work by Hochschild (1983) on the service industries and James (1989) on women's health care paid work has reconstructed emotional labour as a major component and hidden expectation in the work of women, paid and unpaid.

James (1989,26) defined emotional work using four points. Firstly, it involves the correct interpretation and understanding of the needs of others and secondly, being available to give a personal response to these. In her third point James uses the notion of 'balance' and the necessity of its provision to the individual (she implies some kind of psychological ordering) and for all the individuals in a group. (i.e. family, institution etc.) Lastly, emotional work involves the actual ordering of work, pacing it and ordering time and people so that the above can be done. Central to emotional work is the availability of the worker to the individuals and, as a form of work, it involves aspects of creating the person and maintaining them in a psychological sense.

However, neither Hochschild's (1983) nor James's (1989) work gives a clear exposition of how emotional work is done or of variations in the format of such work. For example, Hochschild (1983) focuses particularly on the way that airline companies used their hostesses to do 'positive' emotional work and present a veneer of friendliness to travellers. In some ways it is the study of the presentation of fake emotion for commercial purposes, this work has benefits for the customers. But both Hochschild and James present and seem to equate emotional work by women with nurturance and as 'health-maintaining' for the recipient. James (1989,24) briefly notes that in the particular case of the domestic home, the tools of emotional work are varied,

"This work can be carried on in a number of ways, by listening, gentle persuasion, by firm direction, by discomforting the person and by force."

However, neither James, nor Hochschild nor sociologists generally have developed the notion that emotional labour can be done in a negative way. Thus, bullying, aggression and emotional manipulation can be as much part of emotional labour as being kind and understanding. Alternatively, acts such as cuddling and hugging can be perceived as manipulative and not always as purely positive altruistic behaviours.

It seems that the small amount of research that exists about emotional labour needs to be re-conceptualised within notions of power and motive. It is an area in which the experience of informal care is possibly quite different from care as paid work with strangers. Within a framework allowing for a broad range of emotions, care and control become sides of the same coin both with the potential effect of disciplining and ordering behaviour, rather than being opposing points on a continuum.

Care assistants and nursing auxiliaries work in highly charged emotional settings. The people living in the institutions have left their homes (some not through their own choice), have lost their spouses or close relatives, are in pain or have had to accommodate changes in their bodies: in a number of ways they are involved with change and trauma. The home's workers face all the problems of having to manage a large group of people and create a home-like experience and provide emotional support. At the same time they are restricted by time, money and lack of motivation and status. Within these settings creating order is highly problematic and may involve different behaviours ranging from comforting and cuddling to telling residents off and ignoring them, managing emotions as well as facilitating them. In some respects the home has to present order and in this way workers may operate on a means-to-an-end basis.

Within the framework used by Hochschild (1983) and James (1989) these behaviours do not all qualify as emotional work and involve issues of containment and manipulation. Within a broader construction of paid emotional work which might include such issues, women care workers are not just victims of a system which insists on emotional labour skills but does not recognise them, but could also be seen as using emotional skills to order other more

vulnerable people. This is an issue which is not confronted within sociology at present. Ideas about the conceptualisation of care and control and the nature of paid caring work are central in the following discussion of Hazelford Lodge and Bracken Court.

Care As Dirty Work

Everett Hughes's (mainly 1971, but also 1958) conceptualisation of dirty work is useful in our understanding of care work and of women's work. Dirty work for Hughes is not only physically polluting but encapsulates the notion of the morally unacceptable, it involves roles which may make the worker feel ashamed and thus to some extent Hughes argues all work has 'dirty' elements(1958,49-50). Hughes attempts an understanding of dirty work on two levels. Firstly, in the way that dirty workers provide a function for society. On a societal level delegation of such work allows dirty jobs to be hidden and distanced from general life. Such work may become invisible in the type of back regions that Goffman (1959) describes.

Hughes's second interest is in how such workers can do dirty work given its meaning in society. He argues that such work can be subsumed within work routines and that on this level dirty workers may be seen as 'good people' doing dirty work. This is the explanation he gives most weight to but he also allows for the idea that dirty workers may be psychologically different and drawn to dirty work in some way. However, he largely focuses on the former notion and emphasises that the difference between dirty workers and other members of society is possibly one of ability and power to delegate such tasks (Hughes,1958,52). Central is the notion that society needs to delegate and to hide dirty work, including bodily care, and that workers dealing with it are affected by the low status of the work they do.

Women's dirty work may be said to be different from men's. Whether informal or paid, dirty work for women often involves bodily care and although janitors, miners, builders etc. get physically dirty the notion of pollution and of potentially infectious dangerous work is not implicated in the same way. The nurse, the care assistant and the undertaker may be said to be stigmatised and affected by their occupational relationships to the body in the same way.

Hughes notes that some forms of body work are high status, for example medical practitioners to some extent gain prestige through touching the body, mending it and so on. The difference between high status and low status body work seems to be the closeness with which the worker deals with bodily fluids.

The nature of care work in homes, hospitals and other settings involves daily exposure to bodily substances that are considered as dirty and defiling. Lawler (1991,47) argues that trained nursing revolves around such work although part of this involves the delegation of most dirty work to lower status workers, such as student nurses and nursing aides. The dirty work that nurses do has been viewed as being made acceptable through ritual and through reference to metaphors such as child care through which bodily care becomes an extension of maternal care work. Within this the delicate subject of touching bodily parts becomes healing, caring and cleansing and helps to de-sexualise the nursing touch.

The literature on pollution links work with polluting substances to social ideas about women and women's work. Douglas (1966), in her work about the nature of pollution, argues that these polluting substances are often defined as such as they symbolise disorder and a breach of the inner and outer body structures that we are used to. Thus, in Western society such substances are hidden and unacceptable when shown outwardly, except in certain circumstances. Thus vomit and faeces are acceptable shown overtly by a baby or young child and are normalised. For all adults these substances are subject to strict disclosure rules and to not be able to control these bodily fluids is viewed as offensive. Work with polluting bodily substances is allocated within our society to lower status groups, who in some senses themselves have been constructed as lesser or socially polluting.

To have contact with polluting substances is to be in touch with potential contamination. One way to do such work is to rationalise these substances and elevate work with them to a technical or professional removed level. This focus has led medical and nursing staff to apply these barriers even when they are not necessary. Wolfe (1988,220) in her study of nurses and contaminating diseases such as HIV/AIDS and hepatitis found that the use of

gloves and protective clothing was often used when there was no biomedical basis for them. Roth (1963) in research at a tuberculosis hospital found that the use of protective clothing was arbitrary. So some staff members would work in full mask, cap and gown alongside other staff with no protective clothing on. The use of such clothing in preventing tuberculosis spread was at the time unclear in medical research, which led Roth to conclude that its use had a form of 'magical' ritual element. This was used to deal with uncertainty of the risk from polluting substances.

Therefore, even for trained health staff the strategies developed to cope with daily exposure to polluting substances are not always based upon scientific rationales. In the case of care and nursing homes the staff who deal with bodily care are often untrained or poorly informed about the cause of disease and at the same time they are probably aware of the societal understanding of such tasks and have to accommodate the notion of working with dirt.

Section Four: Coping With Paid Care as Work

For the purposes of this thesis caring is considered as paid work. It can be classed partially as a service occupation, which may show features similar to others in terms of mechanisms for organising work and coping with the job. Here two features are discussed one, typification, usually associated with health care and people oriented work and another, resistance, usually associated with industrial, production and object type work. Part of the way the work discourses may manifest themselves is in the practices used in work. For example typification patterns may yield the way the discourse constructs normalised, ordered residents or patients and how it categorises others. The way people are labelled indicates the schemes of knowledge and criteria used for that ordering.

Typification

There is no clear understanding yet of what largely differentiates care workers, untrained nursing auxiliaries and trained nurses in the way they define and typify elderly care residents. This thesis applies the unusual approach of mixing a notion of discourse developed from Foucauldian theory and typification, which is grounded in phenomenological and

interactionist methodology and research. This type of approach is explored in Wardhaugh and Wilding's (1993) paper on understanding institutional living. Foucault provides a framework for analysing knowledge, power and practice as interrelated and the notion of typification illustrates knowledge in the practice of ordering and disciplining. The basis on which typification patterns are created and used gives an insight into the concerns of the workers and the way their knowledge shapes and is shaped in the settings.

Typification is a concept that is fairly new to the Social Sciences, initially associated with the work of Schutz (1971) but now of importance generally in interactionist and phenomenological theory and research. Categorisation of work is an everyday occurrence, categorising types allows action to take place towards things, it organises and allows a management of the world around. Typification is perhaps more important when it is applied not just to objects but other people and the study of typifications has been particularly useful in the study of people work, both in the categorisation and ordering of customers in the service industries and also the construction of other workers within the work setting.

Hargreaves (in Bond 1983,36-37) puts forwards three models of typification. Firstly, he identifies the ideal type model which is useful when considering the service industries and the idea of an ideal customer. Secondly, the 'characteristics model' which presents the argument that typifications work on the use of configurations of characteristics taken from a set. Thus the process is similar to an 'identikit'. Lastly, Hargreaves offers an interactionist based model of explaining typification. This model focusses on dynamic relationships in the setting and the possibility of a range of change in typifications over time and context.

Thus, how typifications are created is an issue of controversy and related to methodological approach. It also seems feasible that the distinctions above are somewhat artificial in research. For the purposes of this thesis, which focuses upon two groups who care for and service paying others, the ideal type model with a notion of possible contextual change is used.

For people who work servicing other people in some way the notion of the 'ideal client' appears central to the typification of individuals. This can be seen as a strong theme in research about health workers (Murcott,1981, Jeffery,1979, Stockwell, 1984, Glaser and Strauss,1972). All of these works identify patients considered and worked with as 'good' and 'bad' by staff. In most the 'good' patient was considered genuinely ill (rather than faking illness) and was compliant to ward routines. In some of these works the idea of stereotyping of 'normal groups' of bad patient was also used, making typification much more complex.

For example, Jeffery's (1979) study identified the construction of the 'normal' suicide who was generally a young female, who staff considered was likely to have attempted suicide for attention. The 'normal' suicide did not usually die from the attempt. From this stereotyped typification staff tended to judge the individual, their background and the way they were likely to behave without knowing the individuals' details. The typification served as a way of ordering the work and identifying likely patterns of behaviour. It was not only based on the 'ideal patient' but had more complex notions of sets of ideal categories of patients (Bond,1983,8).

The importance of the study of typification patterns is that they often lead to certain forms of treatment by others. They are actively used to organise work. In health care research it has been found that the difficult patient is disliked and in the extreme may be avoided or neglected by staff. For example, Glaser and Strauss in 'Anguish' (1972) described the gradual typification and isolation of a cancer patient Mrs. Able as a difficult and demanding patient. This patient's categorisation was compounded not only by her distressing illness but the level of anxiety and degree of attention she sought. Her construction as a difficult patient led to avoidance by all but lower grade workers. No one took responsibility for her care.

Stockwell's (1984) research on typification and nursing identified two typification groupings used by nurses to label patients; the good patient and the bad patient. These labels were based mainly on three types of features; physical: overweight, dirty, having a long term

illness, psychological: over anxious, emotionally demanding, and also moral judgements such as - "does not deserve treatment".

The type of typifications constructed is specific to the individual setting but Bond (1983,11) identifies two broad sets of influences on typification patterns. Firstly, in some typification patterns rational concerns for getting the work done are involved. Secondly, typifications may be made on the basis of "moral judgements". The type of typification patterns reflects the type of work and concerns of the typifiers and in this way it can be particularly informative in understanding work. In the case of elderly care settings it has been noted that the categories of typification are based upon lay and ageist stereotypes and once labelled people are entrapped and genuine attempts to break out are interpreted as insincere or suspect behaviours (Evers,1981,124).

Typification and Elderly Care Work

In nursing there is a central debate over what constitutes nursing work. In theory, nursing work is total patient care, holistic in nature. However in reality much nursing work is task oriented in which people become work objects to be processed, ordered and routinised (Melia,1989,31-38). Elderly patients are less satisfying to care for because they represent more work. They represent classic 'bad' patients who suffer from chronic illnesses often requiring low status, basic but back-breaking personal care, with little or no noticeable medical progress and possibly visible degeneration (Evers,1981,113). The nursing work elderly patients embody is marginal to contemporary notions of nursing involving physical care work and elderly care nurses may delegate most of these tasks to lesser status workers. Thus making contact care work an even more marginal part of their work.

The elderly care nurse is faced with the dilemma of a lack of congruence between theoretical and practical care, and dealing with a lower status patient who is perceived within medical and nursing discourses as dull and difficult to care for. In this setting, typification gives some control and may have the effect of positively sanctioning behaviour that makes the situation more bearable for the worker. Evers (1981) observed wards in a geriatric hospital and identified three categories used particularly to typify long-stay women

patients in which there were clearly rewards for the 'correct' type of behaviour. Firstly, 'dear old grans', these were popular non-disruptive patients who were generally fairly well mentally and physically. The nurses liked such patients because they fitted into ward routine well, did not complain, praised the care given to them and were generally cheerful. Their behaviour allowed the nurses to infantise them, in language and behaviour, as "good sweet children" (Evers,1981,121).

The second group identified by Evers were the "poor old Nellies", many of whom were senile and needed a lot of personal care. Nurses were indifferent to this group in terms of like or dislike but were able to infantise them through physical care and through feeling sorry for them. Lastly, there was an unpopular group, the 'awkward Alices', these women tended to be more demanding and critical than the other two groups they were also more likely to be mentally alert. In terms of physical dependence the Alices were a diverse group but they all tended to be critical of the ward routine, did not pamper the nurses and observed their right to be bad tempered/distant etc. The difference between good and bad patients was the extent to which they fitted into the routine and did not attempt to fight the dependency nurses used in the format of care. Within this framework the Alices were most disliked, were often ignored, and received a lower standard of care.

Evers' (1981) work illustrates the way that typifications can be used to control and order patients' behaviours and offer rewards and negative sanctions in terms of relationships with the nurses and treatment by important others around such as doctors. The Alices were mainly typified by the threat they posed to the ward status quo. It seems pertinent to add that in elderly care settings where death and degeneration are routine the maintenance of order is foremost in presenting an impression of control and camouflaging the more distressing aspects from workers, those cared-for and visitors.

Untrained care assistants and nursing auxiliaries, as well as trained nurses, work in such a world, working within routines to prevent degeneration becoming visible. If staff should fail in this duty as Hockey (1990,100) notes,

"Then the carefully submerged disorder of ageing bodies might rapidly emerge to make visible and explicit the true nature of the institution."

Hockey (1990,39) found that care workers in one residential home in the North East of England partially prevented this scenario via physical typifications of residents as the 'fit' and the 'frail'. Care staff had developed a strong lay linguistic and behavioural scheme in which they divided residents. The labels of 'fit' and 'frail' defined for workers the residents proximity to death and the routine worked around both catering for this state and creating its invisibility.

When fit residents claimed they were ill they were constructed as play acting. In the event of such claims continuing or residents showing symptoms that care staff recognised as serious, residents were re-categorised. Once re-categorised, residents were redefined as more child like, often as dying and as 'frail'. Frail residents were often categorised as looking small, and having a number of 'signs' of death, thus Hockey notes about the categorisation of one 'frail' woman.

"Lacking in medical knowledge, staff nonetheless made grim note of the 'signs' of imminent death, sunken eyes, rattling breath and a bluish tinge to her nose." (Hockey,1990,40)

Despite this, these patients often lingered on for months sometimes being re-categorised by staff a number of times.

The categorisation of residents rested upon an attempt to rationalise work in the face of uncertainty. The 'frail' were those around whom care should be more fully organised and this was mapped out in the spatial movement of the resident to the bottom corridor. Thus in organising care around typifications the workers gained some control over their work.

Resistance

Resistance is a term that does not sit easily with conceptions of care work. It is used to describe acts involved in industrial relations and mass production, traditionally in male industries such as Beynon's (1975) study of Ford production, with the implication of acts of sabotage, union membership and worker instrumentalism. The problem lies in the apparent inability of contemporary sociology to perceive paid care work as part of the public sphere of work rather than as an extension of home work.

In health care literature resistance is dealt with in understanding patient refusal to comply with treatments often within a framework informed by psychoanalytic ideas. In Goffman's (1961) 'Asylums' resistance is presented as the prerogative of the inmates against the staff, resistance by staff is only briefly mentioned as their need for distance from their charges. Yet the care industry, like many of its industrial counterparts, has the kind of conditions to facilitate such action: low pay, poor conditions, difficult customers, lack of security, stress, etc.

Ackroyd and Crowdy (1990) discuss the resistance of slaughterhouse workers to both management strategies and to work within the context of a low status, dirty, socially unacceptable, job. Part of the resistance of workers came from working with social contradictions, i.e. people generally like animals but they also eat them. Resistant behaviours often involved breaking rules and refusing to accept the role given by management. For example, the men organised their own work gangs, refused to change clothing after work, leaving with blood stains on their overalls. Ackroyd and Crowdy (1990,3-4,16) note that attempts to change workers' behaviours were rooted in a top down approach whereas the men organised work on a ground floor level. Ironically, there are striking similarities between those who work with the elderly and slaughterhouse workers.

Elderly care workers deal with socially contradictory categories of people. Thus, some older people are elevated (for example, the Queen Mother) yet others are put away. Care and nursing workers experience being dirty, low status workers through their associations with working with elderly bodies. Management and society often do not recognise the workers' experience as problematic and, as such, work is open to ground level attempts at order to find a way to negotiate such work. Thus, the possibility of care and nursing worker resistance to problematic work, patients/residents or management, remains.

Resistance in health care can also be seen in terms of notions of usurpation and dual closure strategies (Witz,1992,48-51). This is particularly relevant to the case of the nursing home setting which tends to be highly stratified and chore divided between the trained and untrained and finding a place within the hierarchy may be important to workers. The

untrained in elderly care and nursing work, whose skills are not valued by the nursing profession, may possibly find a place in the vague undefined field of social care. Resistance undoubtedly already exists in such work but possibly is informal and is certainly underexplored in academic literature. One could postulate that changes in the structure of nursing and of paid care work may lead to strategies for creating or finding a place which may involve more visible resistance on a formal or informal level.

Conclusions: Elderly Care Work and Control

Care work, paid or unpaid, is liable to increase as an activity (for women especially) as the older population grows. The social and sociological way that women's care work is constructed is as an unproblematic activity. However, care is clearly work which involves a number of highly sensitive aspects of human life: degeneration, body work and pollution issues. How such paid work is organised is central to this thesis. It is pertinent to use the word 'paid' to distinguish this labour from unpaid care because they have been presented as involving similar issues within sociology. Yet, there are visible differences between the care of one relative at home and caring for a number of older strangers, within an organised environment, which is alien to them, and charging for those services. However, some of the acts of care may be the same.

For women working in care homes the daily issues of care are not often involved with the past relationship they had with the residents or with reciprocity or with love of the job, but relate to earning a living and getting through the work. Care work may be chosen as a job because of its convenient closeness to home and because there is the social expectation that it is something women do. There are also clear similarities between this work and other more general forms of work such as heavy work, assembly line work and the service industries. Paid care actually involves people management, the organisation of space and time and repetitive and dirty tasks. It seems that the issues around paid care raise the more general question of how gendered work is understood and the way that changes in society are reshaping such work.

Care has not been constructed as work involving discipline despite the emphasis on control issues in previous work on institutions. But residential and nursing homes are not 'asylums' in the traditional sense, they have institutional features and are also similar to other work places and the domestic home in other ways. These places are linked by the need for a disciplined individual and when viewed as mechanisms for discipline, care and control overlap at points and appear to work towards the same aim. The regulation of the body is necessary in the family, the school and the nursing home.

This thesis approaches the issue of the organisation of work in Hazelford Lodge and Bracken Court from the perspective of the main care workers: the care assistants and the nursing auxiliaries. However, it also challenges and presents a critique of the accounts of work. It does so through ethnographic methods to understand the work discourses, the frameworks of knowledge that the workers practice in their acts of care work. It is not about the perspective of the older people, or the owners or others outside, in this sense it is necessarily restricted. But at the same time, it exposes those with the power of care and the responsibility of creating order.

CHAPTER TWO: METHODOLOGY

INTRODUCTION

It seems necessary to begin this chapter with a brief explanation of my background prior to undertaking this research. Prior to this project I worked in Social Services with adults with learning disabilities for a year. During this period I encountered and accepted notions of clienthood and empowerment and when I first began to think about elder care work I did not question the public image of elderly care homes and the nature and rhetoric of care. I certainly did not expect to find care work underpinned by the conflict of interests and control issues explored in this thesis. I present in this research one account and interpretation of the work of care assistants and nursing auxiliaries at Hazelford Lodge residential home and Bracken Court nursing home.

Hazelford Lodge and Bracken Court were two private homes, owned by the same proprietors and sited adjacent to each other, in the suburbs of a West country town. The difficulty in accessing private provision meant that these two homes were selected on the basis of their accessibility, through personal contacts. The main blocks of data collection (179 hours in each home) took place during September and October 1992, in Hazelford Lodge residential home, and in February and March 1993, in Bracken Court nursing home. However, other data were collected in preliminary visits two months before these periods, in weekly follow up visits for six months after and in continuing regular visits. (April 1994). Both homes are now expanding their services into respite and day service care.

Section 1: Discourse, Foucault and the Thesis

This thesis had initially a broad remit; to uncover the understandings and knowledge of 'hands on' workers in two elderly care homes. These groups of workers are largely invisible in the sociological discussion of care work. The initial focus of study was wide-ranging; it was about health and social care work, the categorisation and management of bodies and minds and the organisation of care in space and time. The theoretical notion of discourse was present from the inception of the research as an underlying presupposition that care assistants and nursing auxiliaries had their own forms of knowledge used in the work place but that the formats of these were unknown.

My interest in the Foucauldian notion of discourse took a 'whole' perspective of interaction. This included not only verbal accounts but also encapsulated the notion of discursive practices. This was particularly useful as the notion of elderly 'care' subsumes under it a number of different practices and beliefs, from the construction of the elderly as childlike to practices of physical restraint or even affection. It also seemed plausible that 'care' in the domestic setting is constructed and practised differently to 'care' given in residential or nursing homes. Therefore, the unveiling of practices seemed central in understanding paid care work.

The theoretical notion of discourse is utilised in this thesis as an analytical tool which allows the study of physical and emotional acts of care along with the ideas of knowledge and understandings which underpin them. However, use of the term itself is problematic. Prior (1989,2), in his discussion of the discourses around death used in Belfast, emphasises the array of ways in which the term has been used by the social sciences and the confusion thus created. Discourse analysis focusing on discourse as a spoken phenomenon has been used in semantics and linguistics, and by psychologists and scholars of literature.

The notion of discourse as language seems pervasive as this understanding and method has also been used in Sociology, with only a secondary notion of the importance of

discursive practices. Although we have studies of discourse in a number of sub areas in Sociology, for example, science (Gilbert and Mulkay,1984), television (Allen,1991) and lay health care (Chamberlain, 1982), the meaning of the term for each is slightly different.

Similar to Prior (1989), my notion of discourse is developed from that of Foucault, rather than being from a discourse analysis perspective. This recognises that things are not distinct from discourse but they are realised through it. From within different discourses things have a different emphasis and meaning, however, things cannot be said to be correctly sited and understood from any particular viewpoint. For example, for Prior, death is a multiple phenomenon, its discourse constructed by a variety of practices, places, people and knowledge. The meanings of death are sited in a number of places depending on the realities involved. Thus, the pathologist's view does not have primacy over those of the funeral directors or the relatives.

Discourse from this definition, can be used as a mechanism to theorise in a broader way than reality as things and ideas constructed purely in language, as Prior notes,

"Discourse ... is not merely a narrow set of linguistic practices which reports on the world, but is composed of a whole assemblage of activities, events, objects, settings and epistemological precepts" (Prior,1989,3).

Ransom (1993,123) highlights the power dimension to discourse.

"Discourses are not merely linguistic phenomena, but are always shot through with power and are institutionalised as practices".

Thus, within a Foucauldian framework, discourses may be seen to have two important features, language and discursive practices and within these there are limitations to what can be said or enacted.

But discourses as schemes of knowledge, can also be perceived as productive and creative, facilitating understanding and social action in certain directions. For example, discourses often work to normalise, to create and sustain a norm and to create conformity in individuals (Ramazanoglu,1993,22). In this way Foucault's conception of power is not repressive but productive, but within restrictions. In addition, the exercise of discourse is productive in creating forms of resistance to it by individuals and thus producing other

forms of social action. Discourses also work to exclude other forms of thought or practices through their construction of 'truth' (Dant,1991,128). The 'truth' of a discourse may not arise from how it relates to dominant forms of knowledge but their practitioners may behave as if they have truth (Dant,1991,129).

However, Foucault was not concerned with ascertaining truth or falsity as inherent in discourses. He perceived their historical development as a disjointed and discontinuous set of changes in which discourses are in potential conflict with each other for primacy and truth. From this perspective social research becomes an issue of the analysis and critique of discourse, as Dant (1991,8) comments,

"Analysis need not debate the truth or falsity of knowledge, it can provide a critique of it by analysing its origins in structural, wider discursive and social contexts".

The origins of knowledge and ideas are particularly important as they site it within certain constraints which are often hard to modify or remove later.

The thesis utilises the broad Foucauldian notion of discourse, as schemes of knowledge which are most visible in their application and exercise. It is concerned with the origin of the knowledge used by low status care and nursing workers, the practices stemming from knowledge, and the way these are maintained as part of what workers do. The research focuses on themes which are also central to all of Foucault's work; the importance of the creation of the disciplined individual, both in body and mind, and the problematics of the transgressing individual. Although care assistants and auxiliaries are recruited from similar backgrounds, each group has a particular discourse and which is exhibited through the work practices.

There were similarities between my subject matter, theoretical perspective, and methodology and other pieces of research such as Prior's (1989) study of death in Belfast, Fox's (1992) work on the organisation of surgery and Hockey's (1990) ethnography of a residential home. These also focused upon the construction of bodies through discourses or social practices and the importance of time and space to these constructions. Thus, Hockey used participant observation to reveal the way that residents were spatially

moved around a residential home in line with the level of health or illness workers deemed they possessed. Those considered frail were moved onto the bottom corridor which was a closely observed and hidden area that was also spatially close to the exit of the home. Fox's (1992) work highlighted the link between power, space and practices in the routines of surgical work. He argued that in surgical procedures the power of the surgeon was embedded in spatial demarcations between surgery and the outside. Thus ethnographic research methods had been successful in similar projects in the past.

Ethnographic research seemed to present the most feasible and accessible route to the schemes of knowledge used in the settings. The research would need to attempt to understand the care assistants' and auxiliaries' constructions of their work, involving a discovery of the subjects' own meanings, vocabularies and priorities. This would produce an 'inside out', rather than an 'outside in' view. However, the thesis presents a somewhat different perspective in methodology to feminist methodologies portrayed in discussions such those of Oakley (1981) and Finch (1984). Feminist research methods have tended to present women's accounts of their experiences without question or a critical analytic stance. This can be seen as a valid attempt to redress the male construction of the world and experiences that sociology represents. But this thesis, whilst seeking an account of the work and experience of the care assistants and nursing auxiliaries, presents a critique of those accounts. For example, the analysis has tried to go beyond care as an acceptable justification of practices to explore the understandings behind caring acts. It is only in this way that the research may question common-sense notions about what care is and how women do it.

Initially, I envisaged three approaches to data collection. Firstly, non-participant observation. This had to be non-participant mainly because my own physical capabilities would not allow me to undertake heavy work and secondly because it does not seem convincing that participation makes for a better insight or better note taking skills. Secondly, I assumed that there would be some kind of documentary data available for analysis from the two types of workers. However, it transpired that the auxiliaries did not have responsibility for record keeping, information was purely passed on by word of

mouth. With the care assistants there was a strong tendency towards verbal story accounts, although they did use communications books to give official accounts which were often written up hours after events.

Thirdly, I hoped to carry out interviews after the block observation periods to ascertain the similarities and differences between accounts given in observation and those given in interview. These proved to be very difficult to gather, especially from the nursing auxiliary staff because they experienced harrowing events at work, for which they had developed strategies that protected them from closeness with patients. Thus, work was something to be escaped from at the end of shifts and home was a separate place where work could be forgotten. In stark contrast, the care assistants talked of work as an extension of home and of residents as like family. However, in both settings the observation involved long interviewing, often in private spaces out of earshot of others. Therefore, the observational data overlapped into interview style in places.

Finally, three types of data were collected in Hazelford Lodge residential home but only observational material and a few interviews within Bracken Court nursing home. However, the observational material from both was quite extensive, involving observation of practices and in-depth interviews. This material yielded the most detailed insight into the workers schemes of knowledge and is given priority in the text due to its repetitive observation in the settings. Observations and conversations were systematically collected, to allow for different times, contexts and subjects. After approximately an hour of observation the notes were written up with as much detail about conversations, events and actions as possible. In Hazelford Lodge this took place in the sleeping in room and at Bracken Court nursing home in the staff room. Both these spaces provided a secluded setting for note taking. Also a research diary was kept to maintain a reflexive account of research.

The Status of Ethnographic Research

At this point it is necessary to discuss the status of ethnographic research within contemporary sociology. Ethnography was originally developed and used by

anthropologists in other cultures. Its usage then moved to the study of home cultures and especially the study of life at the bottom of the social structure and of deviance (Spradley,1970, Humphreys,1970, Goffman,1963). It has also been successfully used in studying religious orders and behaviour, and has been applied to the study of work, especially factory and assembly work (Beynon,1975) and occupational subcultures, including the factory work of women.(Pollert,1981) and education (Willis,1979, Ball 1981)

In health care settings ethnographies have presented in depth studies of hospital social life and order. For example Roth's (1963) classic work on time and passage in hospital patienthood, Stockwell's (1984) work on patient typification by nurses and Glaser and Strauss's (1968,1972) work on death and dying in the hospital and other settings. An interest has been shown in using ethnographic methods in the study of elderly care settings including the geriatric ward (Fairhurst 1990, Evers 1982) and in residential and nursing home care (Hockey 1990, Paterson,1977 and Gustafsson,1972). It is clear that ethnography can provide different accounts from quantitative or other qualitative methods, that it could be argued, are more clearly grounded in the participants' views of their world. Alternatively they could be said to be grounded in the researcher's view of the participants' views of the world. However, questions have arisen over the validity and presentation of ethnographic research, its relationship to theory and its role as reliable social research.

Hammersley's (1990) critical article on ethnography in 'Sociology' has fuelled contemporary academic debate as to how ethnography should be carried out, the way ethnography presents theoretical description, the validity of this as theory and its place as a method within contemporary social research. Hammersley's criticisms centre around what he suggests is a lack of fit with methodological rigour; and he negatively equates ethnographic theorising as similar to "common-sense descriptions" (1990,609). Secondly, he argues that ethnography is open to "become a vehicle for ideology" (1990,610) because of an insufficiency in thorough description of the values and

assumptions of the researcher. However he still remains committed to this form of research.

Stanley (1990), in response to Hammersley's criticisms of ethnography and ethnographic practice, argues that his perspective is founded upon the values of the positivist tradition within sociology and upon the validation techniques of the natural sciences. But these are wholly inappropriate for ethnographic research. She argues that although ethnographic accounts may not always fully explain the values of the researcher, the problem of the presentation of written work as 'truth' affects all forms of methodology and sociological accounts (Stanley,1990,619). Therefore, without the use of thorough reflexive input, all forms of methodology could be criticised for mystifying knowledge and presenting accounts as truth.

Social science discourse until very recently maintained the positivistic assumption that it could create order out of disorder in the social world via theories and structures of its own creation (Brittan,1989,147-152). However, the post modernist recognition of multiple subjective realities and the understanding that truth is subjectively constructed, means that no account, can be perceived as the 'truth', as the world is socially constructed and therefore relative to those who are experiencing it. To minimise this problem it is necessary to utilise reflexivity in understanding one's own academic sociological reality. Within this framework ethnographic accounts cannot and should not 'stand up' to the methodological yardsticks of the natural sciences.

This thesis can be perceived as one account of workers at Hazelford Lodge residential and Bracken Court nursing home and their work, but it does not have primacy over others. There are other accounts available: those of the residents/patients, trained nurses in the nursing home, the relatives, the owners and others. The focus of this study is the care assistants and nursing auxiliaries who have the most contact and do the physical and contact labour with residents and patients, but it still remains my account of their account. To redress this some of the data and analysis about organisation of care, conditions

within the homes and data on resident typification have been fed back to the care assistants and auxiliaries and have met with a positive response.

We know little about the experience of carers in residential and nursing homes, how they order acts of care and justify them. Care somehow happens and is judged as good or bad by the final state of the resident or patient. However, behind the condition of the constructed individual lies a body of knowledge about how to create him or her and about appropriate values and behaviour and this body of knowledge is used and maintained by the workers. Hopefully, this thesis has some validity and resonance to the women who were studied as well as having some correspondence with the general contemporary experience of working in paid care. But at the same time this account differs from purely being an acceptance of the rhetoric of care. Through a grounded description and analysis of the discourses and practices of paid carers it attempts to challenge the way paid care is undertaken and understood, by revealing the mechanisms by which it is done.

Theory and Reality in Ethnographic Research

Having decided on ethnography as the appropriate method for data collection it was astonishing to find that manuals (such as, Hammersley and Atkinson, 1983, Burgess, 1984, Strauss, 1987) were generally inadequate to prepare one for the experience of field work. There is a tradition in ethnography which maintains that to understand the world of those being studied one has to understand the meanings of the group; whilst at the same time preventing both over involvement and over detachment. But the issue of how to negotiate a role and relationships with the researched, which have become important on feminist research agendas, appeared underdeveloped and were certainly viewed as unproblematic in general ethnographic texts. But, for example, the women workers in both homes studied seemed to emphasise the importance of the unveiling of one's life and experiences. 'Collecting' data was bound up with a process of bargaining personal details within interaction and this was necessary to create rapport. Field work as emotional work raises issues about personal boundaries and in many ways the ethnographer is left to fall back onto his or her own communication skills or the role given to them by the subjects of the research. These issues are under explored within ethnographic texts.

For example, in Hazelford Lodge residential home, I was able to latch onto a role given to me by the care assistants, that of 'student'. The role of student constructed me as junior, young, learning, and unthreatening and it allowed a form of youthful stupidity in which it was acceptable to ask questions and take notes. However, in Bracken Court nursing home, my role was more problematic as I was constructed as a 'professional' by the auxiliaries. Doing physical labour appeared to be a dividing issue between ranks and as a non-participant observer my rank was unclear. Later, through 'putting in' time, I gained staff respect via the notion I was hard working.

Personal danger has only been recognised within ethnographic texts in terms of the physical danger encountered by researchers when collecting data on deviant or criminal activities. But to research issues such as, body work, bodily degeneration, death, pain, ageing, abuse and mistreatment, is to threaten the core of oneself, it is an emotionally dangerous pursuit. It is also clear that emotional danger sets different research questions and agendas from physical danger. In the case of this research, the data collection was emotionally stressful. However, this experience was also useful as this experience is presumably not dissimilar to the experience of new workers being socialised into the care assistant or nursing auxiliary discourse of paid care work.

How Were The Data Analysed?

Initially there was some indecision about how to analyse the data. There are a number of qualitative analysis computer packages available. I realised that most packages had a fairly mechanistic view of language but that the nature of care workers' talk was often metaphorical, based on tone rather than content. I felt these kind of nuances may be lost when using a computer package, so I decided to work by hand. This transpired to be a lengthy and detailed chore but one that allowed a strong knowledge of the data.

I was influenced by ethnographic texts in the collection and analysis format selected and similar to many ethnographers, Glaser and Strauss's (1967) notion of 'grounded theory' was useful as a starting point. They argue that theory should be created from continuous

analysis of data until a theoretical saturation point is reached. To do this the observation and comparison of similar and dissimilar events is necessary to challenge and reshape theory in a processional fashion. Therefore, the theory was grounded in the data and developed over time.

However, I found that although some analysis was done as the data were collected and theoretical ideas were also developed within the research diary, most analysis was undertaken once all the material on one home was collected. Through a re-reading of the field notes and meticulous re-writing into very basic categories of topics, sets of data were used to draft regular basic reviews of the main themes developing from the data developing. I had little idea of what would emerge from the settings and allowed the data to lead me into further ideas. I was able to test some of the ideas in further observations and interviews but found it hard to gain a strong response to interviews from the subjects.

Access and Role

Access was obtained through local connections in the West country rather than through a formal process of entry. My gatekeepers were initially the owners who, in discussion with the Matrons of the homes, allowed me access. I also had the workers themselves as a third group to negotiate with and they in turn often negotiated with residents and patients to allow me access. The owners and Matrons were given a full account of the broad aims of the thesis, other workers were told I was trying to understand how they did their jobs and what these entailed.

I arrived at both homes as observer as participant but as Fairhurst (1990,107) notes, typologies of ethnographer roles such as of the 'complete participant', 'participant as observer', 'observer as participant' and the 'complete observer', are problematic as they suggest a researcher can choose a role and that these are well defined (see Gold,1958, Junker 1960). However, I found that my role appeared to be out of my control once in the field. Furthermore, the explanation I gave for the research to both groups of workers, that I was interested in their jobs, evoked very different responses in each setting. The

nursing auxiliaries in Bracken Court initially appeared to find this threatening, it smacked of assessment and officialdom. Time had to be invested in allaying their worries and developing rapport. In comparison, the care assistants were delighted that anyone should be interested in their work.

Getting consent for access to residents and patients was ethically problematic. In Hazelford Lodge residential home most residents could be asked permission for access to their rooms etc. However, in Bracken Court nursing home, where many patients were affected with memory loss, consent could be given one minute and forgotten the next. The distinct categorisation of data collection as covert/overt became obsolete. Although I had the main gatekeepers' permission, neither their consent nor that of relatives convinced me I was ethically correct. Informed consent was also problematic as many of the residents and patients in the homes were lonely. Thus some, despite reassurances, could have been afraid to deny access, or could have been desperate for company. I felt there were power issues present that I had little control over. Most of these have remained unanswered (see also, Butler, 1990, 162-170).

Access and role appear in methodological texts to be a rational, organised choice, often decided upon by the researcher. However, I found that this was an area over which I had little control and that was affected by luck, personality and the view of the research taken by the subjects. Central to the 'finding a role' issue is trying to not to offend and break the rules of those you are studying. But the roles and behaviour of subjects have to be discovered as part of the research and it is the day to day grind of messing up and continual face to face work which wears the ethnographer down. In comparison, negotiating with the initial formal gatekeepers was relatively easy.

Section Two:

A Reflexive Account of Access and Relationships With The Workers

In this section I wish to discuss my presence within the research process and some of effects this may have had upon the data generated from the settings.

A/ Hazelford Lodge Residential Home

From initial visits I found Hazelford Lodge a fairly relaxed place to be in. There was one main grade of staff, care assistant, one part-time cleaner and work was organised as a team effort. The physical organisation of the home was also reassuring as a setting for research. The assistants worked with the residents mainly in the lounge area, which was domestic in design and there was something rather ordered and comforting about the clusters of elderly people sat chatting, reading and knitting. The lounge presented an initial impression of non-threatening elderly care work and the residents appeared lucid, capable and happy. I felt quite at home in this setting where order appeared so innocuous.

However, I soon discovered that the lounge space was not the main area in which the assistants organised care or discussed their charges. The care assistants had colonised the cooking and eating areas and it was here that I gained the most in-depth data. The kitchen for the workers was the centre of their occupational subculture and where they seemed most relaxed. Here residents were discussed, their behaviour analysed and typified, lewd stories were told, the owners mocked, swearing went on and food and drink could be eaten illegally. It was access to the staff area of the kitchen that I needed and the care assistants at Hazelford Lodge gave me access to this area very quickly. This appeared largely due to the lack of hierarchy between the workers, Matron was untrained, uniforms unregulated and there was little emphasis on rank. There was a general view amongst assistants that work was similar to domestic labour and any woman could do it. I also was constructed as in need of care and it was mentioned on numerous occasions that I did not eat properly and my clothes were not ironed correctly etc. I was also seen as being 'a bit of a laugh' and as being 'ordinary' as opposed to 'snobby' because

I was prepared to observe even the dirty jobs. Access thus hinged on my construction by the care assistants as unthreatening, and this was a process over which I had very little control.

Introductions and Role

The 'harmless student' construction could be perceived in the way the assistants explained my presence to residents, they emphasised my interest in the work as learning rather than as assessment.

Eileen: "This is Geraldine, she's come to see what happens in a care home."

Maggie: "This is Geraldine, she's helping me today."

At first the care assistants appeared to want to be chosen to be observed and all appeared glad to have someone interested in their work. But they also seemed stunned at my interest, as they felt their work was not 'real' work because of its domestic nature. Having such eager subjects made data collection easier sometimes, but I had to remain mindful not to concentrate on particular assistants who were enthusiastic to be observed.

Within a few days, my constant presence meant the novelty had worn off, and I was assigned the role of 'young student'. The 'young' was not chronologically grounded but appeared to be based around my perceived inability to care for myself. Initially this annoyed me. For example, I felt offended when an assistant took some toast off my plate and put more butter and marmalade on it because it, "wasn't buttered properly" and I, "needed looking after". However, when viewed in the context of the home, and the treatment of residents and relatives, this behaviour became valuable data about the way people were accepted as 'belonging' to the home. The care assistants liked to care for the vulnerable resident or the relative who could not cope. The smooth working of care relationships was based on individuals accepting and allowing the care assistants to control their environment. This acceptance of care and visible gratefulness appeared to be part of the underlying reciprocal relationship expected by the assistants.

This led me to pay attention to the notion of boundaries within the home and the notion of 'belonging'. Inside Hazelford the divisions between bedroom and lounge were not strong, the most guarded boundary was between the inside and the outside worlds.

Getting into such a place is difficult in itself and gaining acceptance was based on a strict set of criteria. For visitors this involved showing themselves to be accepting and non-disruptive to the routines, and allowing themselves to be 'cared for'. Thus, making drinks and the serving of small pieces of food was care assistant behaviour, visitors who did the same transgressed their role. Visitors were also expected to verbally allow access to their private lives.

The 'belonging' status gave the bearer some status above others entering the home. This was illustrated by an event which occurred three weeks into the research, when a new worker came to the home and did one evenings work on trial. Late in the shift she spoke to me in the kitchen saying that she despised "my type" who were not prepared to "get my hands dirty". The worker only did one shift and decided not to take the job. The next evening when I recounted the event to the night staff they became angry.

Kath: "Coming in here with all her airs and graces .. you belong here more than she did, I'm going to tell Matron."

By the next evening it had been decided that the woman was not only a "silly bitch", but also an incompetent in relation to me.

Just before I went over to the nursing home it was strongly expressed to me by all the care assistants that I would find "The other side" a difficult place to be in.

Karen: "You won't be able to have a laugh like you can over here with us, and you'll have to mind your Ps and Qs."

Eileen: "You won't like it at all but you can always come back over to us when it gets too much."

It was clear that the territorial attitude that the care assistants expressed about me, was reflective of a more general attitude toward 'their own'. It is difficult to say exactly how being given a belonging status effected the data collection and analysis. In some ways, it possibly fostered some empathy with the assistants, but I was also glad to leave. Hazelford was oppressively supportive as it functioned as a total world for its residents and workers, and I felt ambivalent in my empathy to the assistants as it felt that 'caring' was the method and justification of their control.

B/ Bracken Court Nursing Home

I found my preliminary visits to Bracken Court nursing home very challenging. Many of patients' behaviours were distressing and the home was generally a sensually confusing place. There was constant noise: a three part harmony of odd expressions emanating from the bottom corridor, the buzzer was continually ringing, there was clanging from the kitchen and television and radio noise was incessant. There was also the oppressive dry heat, strip lighting and offensive smells; bleach, disinfectant, excreta, cheap air freshener, which were encountered throughout the home. My initial diary entry read, "7am. Arrived, wanted to go home".

The home was hierarchically ordered under a trained Matron. In rank the nursing auxiliaries were placed above cleaners and laundry women and below all the trained nursing staff.¹ In the preliminary stages of research I only met the trained staff who colonised the public areas of the home: the lounge, foyer and Matron's office. Occasionally I saw a fleeting glimpse of a green auxiliary uniform as patients were wheeled into the lounge, or as they disappeared up the backstairs. Thus, despite my weekly preliminary visits I could not establish as strong an initial rapport with the nursing auxiliaries as I had with the care assistants. This affected the research by making the collection of data difficult in the first week. Rapport was established during the early days of the block observation, when the auxiliaries observed my continued interest and presence.

Introductions and Role

I introduced myself to the auxiliary staff as someone who wished to understand what they did at work and why they did it. However, despite my attempts to explain this and my very casual appearance, the role initially given to me by auxiliaries was that of a 'professional', a person of knowledge who was externally assessing their work. I even became concerned that this was being used by the auxiliaries to control patients.

Vera (To a patient in the bathroom): "This is Geraldine, she's going to write a book, so you'd better be good or she'll tell about you."

¹ See appendix 1 for tables of staff numbers and rank.

Cary (having been slapped by patient): "Don't be like that, this lady's writing this all down and your name will be across the top."

I found, as in Hazelford Lodge, that I had little power to effect change in my role.

The auxiliary staff initially perceived me as potentially much more threatening and powerful than the care assistants did. Most were afraid that I was working for the owners or was possibly some kind of inspector from the Department of Health. It transpired that a few weeks before my arrival a friend "from industry" of the owners had come in and timed the women working. Most of the women had no idea what he was doing.

Vera: "Even timed us in the loo, thought he was a perv."

However, later they became concerned that they were being tested to make sure they were working. Then I arrived. I overcame the auxiliaries' fears by showing them my field notes and showing willing to "slag off" the owners. But it was mainly through spending a lot of time in the home solely with the auxiliaries, that they began to view me with less suspicion, rather than as above them in rank. In some ways this made me worry whether they had really consented to my presence or were too scared to refuse in case I was some kind of official. However, I was unaware of the effect of the highly structured nature of the home and the fears and suspicion of auxiliaries to other ranks, until the block observation was well underway.

Finding out what had happened during the hours before I arrived at Bracken Court was difficult. Trained staff tended to withhold everything but basic information from the auxiliaries, and I suffered the same fate. In formal reports auxiliaries were told very little, whereas trained staff had extra informal meetings and any attempts by auxiliaries to discuss patients' situations further in report sessions was repelled by trained staff. Also the shift system and the part-time status of auxiliaries meant communication problems were inevitable. I originally perceived this as a problem, but I later realised that the auxiliaries collected and created information about patients and did not rely on the nurses accounts. The auxiliaries made their own accounts of events which had lay and nursing elements.

Spaces, Retreat and Escape

I thought note-taking at Bracken Court would be difficult as, unlike in Hazelford Lodge, where the separate sleeping in room was available, the only space I could use was the 'staff' room which I thought would be in constant use. However, when using this room I discovered that the auxiliaries were not allowed to use the room during shifts (this was seen as avoiding work). In brief, the auxiliaries suffered from a deprivation of space, information and status at work, and for most of them their general aim was to find other employment and escape work at Bracken Court.

I could empathise with this aim, and the feelings of despondency and disillusionment expressed by the auxiliaries. The staff room at Bracken Court became my retreat from the distressing and emotionally threatening state of patients, and the often insensitive behaviour of the auxiliary staff towards them. There was also the general regimentation of time and space, a constant sense of task orientation and the continual processing and movement of patients in a 'fit' state from one place to another. The general routine and ritual behaviours of the auxiliaries appeared to have the effect of creating patients who were more pliant to the home's aims. I became furious at the overt processing of bodies and writing up notes became a meticulous obsession, noting expressions, physical behaviours and props as well as words and settings.

Night auxiliary work was the most difficult to observe. Mistreatment and depersonalisation were systematically used to get through the work as quickly as possible. Patients were overtly worked upon as objects; toileted, cleaned up, rolled over etc. Sometimes punishments would be used to get back at patients or make life easier. For example, hiding buzzers or ignoring patients was standard. But it was also highly difficult to maintain empathy with any of the auxiliary workers, despite their poor working conditions and the general stress of the job. The feelings of empathy that I expected to be able to create and maintain with my women subjects, were not forthcoming. After the data were collected I needed space to reflect upon the auxiliaries' behaviour, the situation, and my own understandings of their work discourse.

During the data collection in Hazelford Lodge and Bracken Court, I found myself lost in the routines and I focused on life within the homes for the two four week blocks of observation. At the end of each block I was tired and dispirited, but in the case of Bracken Court I also felt angry and worried for the well being of the patients. I had to put the data away and distance myself from it for some weeks before I could begin to process it.

Endings and Disengagement

In the case of each of the homes, as I neared the end of the block observation I began to know the routines, the rules and work subculture of the workers. For example, in Bracken Court when observing interaction in a patient's room I knew approximately how long we would spend there, what kind of work would be necessary and the usual format of the interaction. In Hazelford Lodge I knew how each resident was typified by the care assistants, where they sat at lunch or in the lounge and the staff nicknames for each resident. It took some time to lose part of this information and to de-institutionalise myself. After leaving I realised how comforting it had become to have somewhere to go each day, somewhere where time was ordered and meals were served on the dot. I could understand how old people got used to being ordered and how workers got used to ordering, but it still made me uncomfortable.

Disengaging with the homes is still in progress but the homes have changed since I undertook the main blocks of observation. For example, only six months after the main data collection five of the residential home residents and nine of the nursing home patients had died and been 'replaced'. Staff had moved onto other work in both homes but in Bracken Court more full time staff had left. In this way the homes now have an air of being different but the same, the routine remains supreme above and beyond who does the work and who lives there. In Bracken Court this feeling is particularly disturbing as death has little ceremony attached to it and news of deaths are tacked onto interaction as workers sweep by you in the corridors. Movements in and out of the home are part of an ongoing process and at death the bodies move out of the side entrance at hours when few people may see them, as if the patient had never been admitted. Although in Hazelford

Lodge residential home death and personhood still have some meaning, control is still entwined with care and there is still the sense that the routine is indestructible and inevitable.

Conclusions

This study is unapologetically about the discourse of the main 'hands on' workers in the two homes studied. With the focus upon revealing discourse, a methodology was needed which could uncover both the frameworks of knowledge used, and the way these were enacted within the practices of work and the order of the homes. In this respect the ethnographic methodology has been quite successful and as a result of the focus on knowledge and practices, issues such as space and processing, play a strong role in the data chapters. It seems that research on any form of body labour could benefit from a similar theoretical and methodological approach. However, I believe the research design could have been stronger had the field work focused on either nursing or residential home provision. The data illustrate that in practice they are two very different forms of care work.

It may also have been beneficial to have spread the data collection over a longer time span, to balance the physical and emotional stress of the research. The practicalities of ethnographic research strongly affect its conduct and success, and although methodological texts introduce notions of fatigue and emotion, they remain inherently understated. In planning it seemed quite feasible to observe five hours at a time writing notes up each hour, but during field work one is doing the leg work of the worker plus thinking work and attempting to constantly present oneself as interested. Once home from the setting the notes have to be ordered and re-written. Thus, in retrospect it might have been useful to collect data in short batches but over a longer period.

Also, I undertook much of the observation in four week blocks without a break, to gain a sense of continuity. However, the sense of isolation that this induced was probably unnecessary, and I suspect did not give more continuity than another approach could have. Although the research serves as a snapshot of the homes at the times studied, extended visits before, and especially after, the block observations have been useful in verifying and developing some of the issues that emerged during the four week stints. Hopefully this research does reflect the experiences of those studied and others who do

paid care. But additionally, it critically discusses the way this work is done, the knowledge behind it, and the notions of care and control which surround it.

CHAPTER THREE: SOCIAL FEATURES OF THE HOMES

Introduction

At the time I observed Hazelford Lodge residential home and Bracken Court nursing home, they were under going changes. This reflected the more general modifications in nursing work and the elderly care business, which was, and still is, going on across Britain. The introduction of the Community Care policies on April 1st 1993 were a few months away, and the owners were tightening standards ready for inspection under the new rules. Also workers were being introduced to the idea of undertaking the National Vocational Qualifications in Care (levels 1 and 2) in the next few years.

The owners of the homes were organising to pay for all care assistant and nursing auxiliary staff to undertake these qualifications. Many of these staff had few formal qualifications, but only the care assistants seemed willing to go back to studying. In Bracken Court the nursing auxiliaries' attitudes to qualifications were negative, with most arguing they were already trained through their contact with trained nurses and that they represented qualifications, "for stupid people" (Julia). At Hazelford Lodge, the care assistants were enthused by the idea of training and obtaining a qualification for skills they largely did not recognise as important.

The months of observation at Bracken Court nursing home coincided with exceptionally low staff moral. All ranks of the staff were coming to terms with considerable changes in their work. The home had experienced four different Matrons in eighteen months, there was a constant shortage of trained staff (RGNs or RMNs and ENs), and Enrolled staff were busy reconsidering their careers in the light of changes in the structure and training of nursing. The auxiliaries were experiencing new rules, new uniforms and new training, and general staff turnover was high.

Hazelford Lodge residential home was much more stable in its structure. There was little hierarchy, all the assistants undertook the same work chores, there was an extremely high team spirit and turnover was lower than at Bracken Court. As a staff group these women

socialised together and often treating Hazelford Lodge as a informal coffee bar after work hours. They also baby-sat for each other, lent each other things, and worked together to make money for the residents' fund. For the nursing auxiliaries at Bracken Court, there was a stronger sense of trying to get through the work on a shift to shift basis and to escape the job.

Section One: Care Assistants and Nursing Auxiliaries

Who Were The Care Assistants and Nursing Auxiliaries?

Hazelford Lodge employees were all employed as care assistants except one woman who worked as the part time cleaner. There was no manager or officer in charge and Matron, who was not a trained nurse, organised care. In contrast, at Bracken Court the nursing auxiliaries were part of a hierarchical order with Matron and the trained nurses having control over the staff below. These groups, in order of status within the home, were: nursing auxiliaries, the cooks, cleaners and laundry women. The care assistants and nursing auxiliaries were treated as having the same job by the owners, which possibly reflected a more general social confusion about their work. Both groups were paid the same amount, £2.75 an hour, had the same job description and terms of employment but despite the adjacency of the homes they worked, socialised and generally behaved as two separate groups, the nursing auxiliaries were being considered by both sides as (the more) superior in rank. The auxiliaries and care assistants treated each other as an 'other', both referring euphemistically to the neighbouring home as 'the other side'. Yet there were similarities in the general backgrounds of these workers as well as some differences.

Hazelford Lodge residential home employed solely care assistants and Matron was untrained, gaining her post through experience. There were five full-time (21 hours+) and eleven part-time care assistants during the block observation period (September-October 1992) all of whom were female and white. Three of these were exclusively night staff, four were weekend staff. There were also two relief workers; one a sixteen year old

schoolgirl and the other Tina, the part time cleaner. The majority of the assistants were local women and all lived within the same post code area.

Bracken Court's nursing auxiliaries made up the largest proportion of staff in Bracken Court nursing home, with ten full-time (21 hours+) and ten part-time auxiliaries to three full and five part-time trained nursing staff. All the auxiliaries were white and all except one were female.¹ The auxiliaries all lived within the city boundaries but they tended to live slightly further from the homes than the care assistants.

Hazelford Lodge had a broad age range of care assistants, from 16-53 years. The range could be better split into two groups, those under 22 (5) and the rest who were over 35 (12). The former group were single, childless and appeared to view care work as a stop-gap. The latter group tended to have children of secondary age or older. In Bracken Court nursing home the age range of workers was 20-52 with the majority of workers in their 30s and 40s. Unlike in the residential home there was a more even spread across ages in Bracken Court, but it was the owners policy that no one under eighteen should be employed because of the "maturity" (female owner) they felt was needed to work with older people who needed nursing care.

Recruitment and Backgrounds

In both cases recruitment was generally informal relying on word of mouth, adverts in local shops and occasionally adverts in the local papers. Although most auxiliaries (16) and care assistants (10) had undertaken some form of paid care prior to their present job, for both groups care work had usually been taken because of its availability, rather than as a positive career choice. All staff, except the school age relief staff at Hazelford Lodge had also undertaken a variety of manual unskilled and semi-skilled jobs in the past.

At Hazelford the care assistants appeared more satisfied with their jobs but in both homes all the younger workers expressed a wish to move into other jobs and made active attempts to do so. Six months after the block observation period only three workers had

¹ See appendix one for more details on the number and type of staff in Bracken Court.

left Hazelford Lodge residential home, all being part time workers. Two of these went to clerical posts and the other to a residential home where a relative lived. At Bracken Court, six months after the block observation, five auxiliary staff had moved on three being full time workers. One went into nurse training, one into domiciliary care, two into clerical work and one to another nursing home. It is interesting that the auxiliary who moved into nurse training was the first ever to do so from Bracken Court, and was also the only male member of staff. Generally it was the care assistants who remained optimistic of a possible career in better paid forms of care, whereas auxiliaries tended to daydream and talk about shop jobs and work other than care and nursing work.

There was some migration from residential to nursing care work within the two groups but not the other way around. Those who had moved from residential into nursing auxiliary work (4) expressed disillusionment.

June (NS): "I thought it was a career move, I've learnt differently since."

This focused on the realisation that nursing auxiliary work did not give the status of being a nurse, that the work was heavy and that the pay, in relation to the work conditions was poor. There were two groups within the auxiliaries, firstly, older workers who appeared to be stuck in the job and who formed the 'core' of work staff. Secondly, those who passed through frequently onto other work, usually not care or nursing jobs. Those who formed the 'core' had often been employed by the home since it opened and seemed the most resistant to change and training. Yet it was these workers who were paired up with new auxiliaries to show them the job.

Job Descriptions and Chores

The owners of the two homes had a joint job description for both care assistants at Hazelford Lodge and Bracken Court's nursing auxiliaries. The stated role of the workers was to create a 'homely atmosphere', help patients with personal care chores and basically do anything else that was asked of them. There appeared to be clear limits to the work that the nursing auxiliaries did at Bracken Court whereas the care assistants undertook a broader range of chores.

The work of the care assistant centred around providing whatever care residents may need. This involved a range of housekeeping work: cleaning, washing, ironing and cooking. There was also physical care work for a minority of residents, such as keeping the residents' bodies clean, dressing them, taking them to the toilet, but all the residents were fairly capable. Entertainment chores were recognised as a fun part of the job. This included: playing games, taking residents 'out' for walks or to local village hall plays etc. It also often involved coercion, as residents were often not interested in joining in but part of Hazelford's image relied on the notion of resident participation.

Emotional and psychological chores, such as supporting, comforting, hugging and cuddling and talking were routinely used throughout the day by the care assistants, but were generally restricted to the most popular residents. Emotional work was recognised by assistants as useful in obtaining certain behaviour, such as getting residents to eat or go to bed. Similarly, it was common for care assistants to use comforters to keep residents quiet including, extra cups of tea, food treats, hot water bottles, hot milk and the flippant administration of pain killers or cough medicine. Assistants used a range of such non-overtly challenging methods to gain good resident behaviour. But emotional work was usually interpreted by relatives as care in action, perhaps because socially emotional work is associated with the domestic home and caring for known individuals. However, at Hazelford Lodge emotional work appeared to be used to cajole residents and make the work easier.

Allied to emotional chores were the negotiation and mediation skills used by assistants to negotiate between residents in disputes over territory and objects, disagreeable comments and to patch up friendships. They were involved in controlling relationships inside the home on a ground level and also in controlling the boundary between the residents and those outside the home. Thus, care assistant work at Hazelford involved providing very similar services to women in the domestic home: housekeeping chores, providing for and creating a setting to live in, ordering the residents interpersonal relationships and

emotions, and ordering and arranging external services (see Graham,1985). However, this was not provision for relatives but for a group of strangers.

At Bracken Court nursing home there were jobs that nursing auxiliaries did not do: cook, clean carpets or furniture, washing, give out drugs, these were other workers' tasks. Auxiliaries were mainly involved in physical care: lifting, cleaning and moving bodies. A real issue for these workers seemed to revolve around the demarcation of status and creation of a distinct role within the structure of the home. It seemed the auxiliaries sited great importance within their role as those who dealt with the unpleasant and heavy work. Auxiliaries were the workers who were expected to restrain the aggressive patient and would move furniture or large objects. This work was much heavier and dirtier than the care assistants work but the auxiliaries presented these features as indicative of its importance. It was 'real' work, hard, tiring and revolting; cleaning, moving and controlling bodies was the trademark of the auxiliaries and they were keen to point out to me that this indicated that they were made of stronger stuff than the "nice girls" on the "other side" (Hazelford Lodge) (Velma).

Too Soft and Too Hard

It seemed the recognition of differences between care assistants and nursing auxiliaries fuelled a general dislike and disdain of each others' skills. On day shifts care assistants from Hazelford Lodge went across to Bracken Court at least once a day to wash larger items of clothing/bedding and three times to collect meals. But when they entered neither the nursing auxiliaries nor the trained staff would acknowledge them. The only workers that spoke to the assistants were the laundry women, the cooks and the cleaners; they too, were largely ignored by the auxiliaries and the nurses.

Part of the enmity between the two work groups revolved around the nursing auxiliaries' insistence that they were harder working than the care assistants. They talked of care assistants as weak in terms of the chores they did which were seen as, "not real work" (Cary) and as less able to deal with the elderly who needed a "firm hand". Within this framework perfect nursing auxiliary work was synonymous with restraint, control and

order. Ironically, the care assistants themselves spoke of the auxiliaries physical care work as 'real work' and appeared to accept and condone their position as lower than the auxiliaries.

Eileen: "The more you look after them (older people) the closer you get."

GL: "Through physically looking after them?"

Eileen: "Yes."

Teresa: "They do a lot of that over there (n. home) and I'd rather do that any day."

Eileen: "I would too."

Teresa: "Before (the n. home opened) we had six (residents who needed a lot of care) to put to bed,(and they) couldn't walk, and I loved it." (Kitchen)

However, at the same time as envying the auxiliaries, the assistants disparaged their form of care as inferior because of the very control issues that auxiliaries felt were part of the job. Auxiliaries were "hard bitches" (Sandy) who were cruel and thoughtless to patients, neglecting them as individuals. In comparison care assistant rhetoric about care was familial.

Maggie: "I treat them as I'd treat my Mother or my Grandmother, we're like family."

This mutual criticism between auxiliaries and assistants could be perceived as grounded in the recognition of the possible antagonisms between the two groups in the future as they struggle to find a place within the provision of nursing and social care for the elderly. In some respects the auxiliaries had begun to create a niche of expertise within Bracken Court's structure. This could be identified as body care and restraint work. Although the position and expertise of the care assistants was less well defined, involving a variety of domestic type roles, this work was distinct in that it did not challenge higher status paid care workers as auxiliary labour did.

Section Two: Work Organisation

Team Members and Underdogs

When the block observation at Hazelford Lodge residential home was undertaken, the home had been open five years. The same Matron and deputy had been in situation for two years and both had worked at the home since it had opened. The care assistants

worked under a Matron, Karen, and Deputy Matron, Julie. When neither was working the responsibility for the shift was put in the hands of the most experienced care assistant. Neither Karen nor Julie had qualifications in care, nursing or social work and although they were paid more, they undertook the same shifts and chores as the other assistants. The status of Matron and Deputy existed in name only and the titles were not used by staff. Also as the assistants were allocated uniforms on the basis of which were cheapest at the stockist, rather than to reflect some kind of rank, Matron and her deputy were not visible in the way that Bracken Court's Matron was.

Matron had been given the job when the previous one had left two year ago, duties she undertook that other care assistants did not included: hiring new workers, organising the work rota, ordering the drugs from Boot's (the chemists), ordering in other services for the home (hairdresser, chiropodist etc.), making the final decision about when to call the doctor when illness was not obviously acute or life threatening, ordering fruit for the home and reporting back to the owners etc.

The care assistants shared out the chores between them with no formal work plan. These included: handing out the drugs at meal times, aiding residents with toileting and bodily care, taking the tea trolley around, folding the washing or escorting residents out in the community. In this way Hazelford Lodge organised itself very much on an informal basis and there was a sense of teamwork. Similar to Hockey's (1990,112-113) findings of care assistant work, altruistic acts, such as offering to do dirty chores and offering gifts, like sweets or cigarettes, were central to the way the assistants at Hazelford organised work. Assistants would rush to help each other with the dirty jobs and being seen to be self effacing in offering to do chores was part of being a good worker. Thus, there was no visible hierarchy and Matron and Deputy Matron rarely need to impose work on the other care assistants.

Temporally work was arranged around three shifts from 8am - 3PM, 3PM - 10PM, 10PM - 8am. Three staff were on duty on any given shift except on nights where two staff were on; one awake and one 'sleeping-in'. 'Sleepers' could be called upon to help,

however to call a sleeper was viewed as unacceptable except in the most extreme circumstances. There were staff who regularly worked nights and the leftover shifts were organised on a rota between the full-time staff. Many workers spent long periods at Hazelford Lodge, leading to work fatigue which affected workers' home lives. However, unlike the nursing auxiliaries at Bracken Court, the care assistants did not complain about the hours and the rota was called the 'work rota', whereas at Bracken Court it was the 'time off rota' suggesting a rather different emphasis. A notion of team spirit was evident and relief workers or 'stand ins' were largely unnecessary as extra work was easily fielded out.

Workers' relationships extended out of the work setting, they mixed socially; went drinking together, communally bought gifts on birthdays and worked together raising money for the residents fund. Thus, socialising was strongly linked to work and the division between leisure time and work time was breached. Most workers appeared dedicated to work; coming in when sick and working extra shifts when staff were absent. There was a notion that they should not let each other, or the residents, down.

The work organisation at Bracken Court was very different from Hazelford's. Firstly, Matron at Bracken Court was 'real', she was an experienced trained nurse who ordered the home on the basis of a rigid division between staff groups and chores. Staff were classified and treated by her in accordance with rank. Staff Nurses had the most power after Matron, they ordered Enrolled Nurses, auxiliaries and other staff and undertook much of the administration and public relations work. Enrolled Nurses were involved in nursing acts, cleaning sores, dressing cuts and occasionally physical care work. Out of all the trained workers it was the enrolled staff who mixed the most with auxiliaries at work and in terms of social events. Also the enrolled nurses had similar concerns about their place and expertise due to the changes in nursing which led to a certain amount of camaraderie between the two groups. Despite this occasional alliance the auxiliary staff remained the lowest upon the nursing hierarchy. Their work was mainly sited in the back areas of Bracken Court undertaking physical care work as the underdogs of the home.

Despite shifts of between seven and eleven hours, workers were only officially allowed drink breaks if taken in the lounge with the patients, but at night breaks could be fitted in more easily. Breaks for food were not allowed and workers found picking at leftovers could be sacked. Auxiliaries were allocated one pale green uniform upon employment. This could only be replaced when it had worn out, which had to be verified by inspection by the Matron and the owners. Smoking was not allowed in the home and those staff who smoked were forced to hide behind the back of the building. As Lucy noted;

"Its like being a kid back at school working here, like hiding behind the bike sheds"

Being caught smoking in work time led to instant dismissal.

It was the owners' policy to ignore the auxiliaries when in the home, only speaking to Matron and trained staff. When the owners were around, which was usually every morning and always in the public areas of the home, the auxiliaries tended to spend less time in these areas than usual.

All the auxiliaries expressed the view that their good will was violated through their work. Much of the dissatisfaction arose from the time-off rota which was supposed to allocate free weekends equally. However, high rates of absence led to many auxiliaries working a number of weekends in a row and many argued that they were forced to choose between their private lives and work.

Example 1

Carol felt that her work life was taking over her home commitments,
"I don't see my husband during the weekdays and some weekends too. In the end I'm being forced to choose between my family and my work and my family comes first." (Staff room)

Example 2

Zara and Ann were discussing the time off rota in the staff room.

Zara: "If she (Matron) hasn't given me that weekend off he's (her fiancée) going to go mad because we're going up to his family and its all booked. If she hasn't he'll be down here." (Staff room)

It seemed that most workers experienced work as something all embracing that radically affected their social and family lives.

Auxiliaries countered the construction of themselves as the low status nursing workers at Bracken Court by verbally constructing their role in mechanistic language as indispensable and as pivotal to the order of the home;

"The nuts and bolts." (Carol, Interview data)

"We're the cogs in this place." (Maddie)

The images the auxiliaries used expressed a sense of ordered movement. This seemed to reflect the relentless structure of care in the home and the way patients' physical movements were controlled.

The auxiliaries felt they had skills that the trained staff did not. This lay in ascertaining and reporting the 'true' nature of what was going on in the home to trained staff, and was part of their way of maintaining control on a ground level and a sense of importance and self.

Ann: "We get them up (patients) we know them ... We tell the trained staff what's going on, they don't know these people and how they are."

Maddie: "This place couldn't run without us, they couldn't afford all trained staff, we're their eyes and ears."

The auxiliaries argued that the home relied upon their hard work.

Section Three: Being Trained and Making Do

Training For the Job

The care assistants and auxiliaries had all learnt their work 'on the job', usually through working with more experienced staff, or especially from a trained nurse, often referred to as 'the old type/school'.

Teresa (care assist): "I learnt off Mary the old Matron here, she'd been a Sister up the hospital."

Carol (Interview data): commented that she first learnt care work from;

"Two middle aged senior nursing sisters, the old type Matron who really knew what they were doing and stood no nonsense, beds and sheets the right way, everything pristine."

Julia (Interview data) explained how she learnt the job in similar terms,

"From two older nursing auxiliaries who'd done the job years and knew what was what."

In these accounts experience and the older age of the trainers seemed important.

The 'trainers' seemed to embody certain values, these were women who knew the job and had done it for years, they got on with the work and expected high standards. They focused on cleanliness, order, working to time and militaristic precision in basic tasks, similar to the way that the Nightingale form of nursing has been presented within sociological accounts of the history of nursing (see Maggs, 1983,102-127). Ordering the patient as part of the environment was central within this format of care.

However, in the case of the care assistants this did not seem to have imparted a similar attitude to work as the auxiliaries. Assistants tended to de-skill their work as, "common sense" (Kath) or "being sensible" (Paula). It was work they felt that anyone could do, or perhaps more specifically any woman. Lay 'care' understandings were seen as more relevant to their type of residents and they labelled this as a 'better' form of care. For the auxiliaries at Bracken Court part of their pride in work was sited within the way they felt that the work was not 'just women's work' and was not easy.

Carol: "Not just anyone could do this and not just people with kids either, old people and children are very different"

The auxiliaries presented regimented care as the premier form of care. In contrast they labelled notions of psychological care, used by the trained nurses in Bracken Court, as "nonsense" (Cary).

These attitudes also appeared to affect how the two groups of workers perceived the new National Vocational Qualifications in Care. Hazelford's care assistants were excited about the prospect of training for levels one and two. They felt training would recognise the skills they had and give them similar skills to the auxiliaries, thus redressing the skills imbalance they perceived between themselves and the auxiliaries. In contrast, the auxiliaries had total contempt for new ideas, qualifications or psychological care. Formal training was viewed by many as unnecessary and resistance to it was strong.

At the time of the block observation the auxiliaries were being primed up by the owners to undertake levels one and two of the national vocational qualifications in care along with the care assistants. Most auxiliaries felt that these qualifications were an insult to their intelligence, qualifications for "stupid people" as Julia, an auxiliary of three years experience, commented.

Julia: "Questions they ask are things like, 'how do you wipe a patients bottom?', I'd put, 'same way I'd wipe my own ... Well if you don't know that when you come you're buggered.'" (Interview data)

The 'girls' at Hazelford Lodge were to undertake exactly the same qualifications as the auxiliaries and within the same study groups, this appeared a point of contention.

The auxiliaries considered that through their contact with trained nurses they had already been trained. They also felt that they knew more than care assistants as they dealt with nursing and medical issues everyday. The younger auxiliaries tended to show their lack of support for training by agreeing to do the course but showing little interest. Older auxiliaries tended to refuse to do the course, some of them maintained that they never would. However, many of them have now reluctantly taken up the course.

Despite the auxiliaries claims that they were trained they had integrated a large number of 'make do techniques' into their daily work, similar to their counterparts on the 'other side'. The owners had devised an economic organisation of the homes based upon a system of quotas for essential care equipment, such as pads, wipes, gloves and washing powder, which were expected to last one month. But these items usually ran out. For example, when auxiliaries applied certain pads to patients this was often not a case of knowing the right one to use but having to make do. They also often had to clean soiled bottoms with toilet roll because the quota of incontinence wipes had gone.

In Hazelford Lodge 'making do' included using substances like salt, sodium bicarbonate and lemon juice from the kitchen to remove stains and wash clothes. Home skills and ingenuities had to be used in place of commercial equipment and knowledge of domestic practice in housekeeping and care were essential for both groups of workers. Thus there

were similarities in the make do skills both groups had developed to cope with the work environment of the homes.

Section Four: Residents and Patients

At Hazelford Lodge the elderly occupants were referred to as residents and during the time of the block observation period (September-October 1992) the home was full. The home was officially defined as 'E' grade, by the Residential Care Homes Act 1984, as able to take physically and mentally disabled or disordered elderly, which gave a basic policy for admission. The final decision on who to admit was Matron's but there was also discussion between workers before a person moved in, especially if they would need more than average help. The age range of the residents was between 79 and 93 with an average of 86 years. Out of twenty six residents, all were white, only six were men, and there were no men above the age of 90.

Residents were generally mobile and lucid and presented workers with social rather than physical needs. Their needs dictated a different type of care, mainly of the mind and occasionally of the body, needing emotional work input. Residents were moved onto nursing care only if they became very mentally confused rather than physically sick. Those that were moved on appeared to share the feature of being incapable of responding to the care assistant's emotional work.

The typical route of admission for residents was from their own homes, and most had lived locally for many years. This led to a substantial overlap in their experiences and those of the assistants, most of whom were also local. Only a minority of residents paid for themselves, most claimed state benefits. The male residents had all previously worked in semi and unskilled work and most of the women had moved in and out of a variety of semi and unskilled jobs, usually to fit in around family responsibilities.

People resident at Bracken Court were referred to as patients and there were thirty-two in total. The age range was from sixty-two to ninety-five, with 26 female patients and 6 male patients. The main problems dealt with were chronic, such as chronic arthritis or rheumatism, cardiovascular problems, and the senile dementias. Despite these conditions many patients did appear mobile to some extent, but use of wheelchairs to make moving people quicker was routine. Most patients also needed physical care, or at least support, for incontinence problems.

The admission background of the nursing home patients was different to that of the residents. Patients generally arrived at the home via hospital transfers or from other nursing or residential homes. Similar to their resident counterparts on the other side, patients were usually local and they mainly came from a working class background. The two homes studied were regarded by the owners as 'reasonable' in price, they argued that the prices were in the middle price range compared to other homes in the town. This may account for the lack of middle and upper class backgrounds within the residents and patients.

Therefore, the homes could be said to cater mainly for very old (over 80 years), working class white women, reflecting the general feminised pattern of admission and residence in elderly care settings in Britain (Arber and Ginn, 1991,13-15)

Conclusions

Thus, there were similarities in the social backgrounds of the care assistants and auxiliaries. Yet at work they appeared to view each other as distinct groups with particular knowledge and skills. The disdain with which the auxiliaries treated the National Vocational Qualifications in care appear to stem from the way that both groups were lumped together for the same training. For the auxiliaries, distinction and resistance to a construction as 'care' workers rather than 'nursing' workers seemed important. The care assistants seemed grateful for anything that would add to, and represent their status and skills. These paid care workers had developed different work knowledge and practices despite being physically and socially so close to each other.

Part of the discourse of each group of workers appeared to have developed out of the way they perceived their place as workers and their understandings of the people they had to care for. Despite the auxiliaries, assistants, residents and patients having similar social backgrounds, workers appeared to use space use and organisation to separate themselves from their charges. It is the subject of the format, ownership and use of space in the two homes, which is discussed next.

CHAPTER FOUR: THE PHYSICAL APPEARANCE OF THE HOMES

Section One: An Introduction To The Homes

The physical structures of the homes were the spaces around which care was ordered. The use of spaces and the way practices were ascribed to certain areas by the assistants and auxiliaries, are important themes in the discussion of the knowledge and construction of work in the following chapters. Furthermore, the expectations one might usually have of spaces and the activities that in general society go on within them, were challenged by the use that the two groups of workers made of the buildings they worked within. Thus, this chapter not only describes spaces but sets the stage for the context of the work discourses.

Hazelford Lodge residential home and Bracken Court nursing home were sited on the outskirts of a major town in the South West of England. Both were private and owned by the same proprietors. They were sited looking in on each other with a large dividing garden and concrete paths crossing between the two. In common with other residential type buildings the homes shared a seclusion from the community around (see, Goffman, 1961,15, Wardhaugh and Wilding,1993,6, Martin,1984). To get to them, one had to turn off a main road onto a gravel path and the car park and homes were hidden from the road by trees.

The external buildings of the homes were similar in some ways; red bricked, squat, two storied. The exteriors of Hazelford Lodge and Bracken Court effectively prevented visitations from outside others because, similar to other residential type buildings, they, "Convey(ed) a public sector image", (Willcocks, 1986,193). Wardhaugh and Wilding (1993,6-7) note that such physically divisive barriers to the outside world not only create an institutional impression to the outside but also separate homes from ordinary moral concerns. This creates a potential for secrecy, abuse and inward looking behaviour in their organisations.

Hazelford Lodge residential home was renovated into a residential home from an old farmhouse and was gradually extended to provide more bedrooms. The front bedrooms,

which were the most visible to callers, were highly customised, housing the most lucid and capable. When passing one could see a cosy view of home life: curios, souvenirs and photographs lined on the window sills, figurines on the dressing tables along with perfumes and cosmetics, books on shelves and expensive quilt and pillow covers belonging to the occupant. This view appeared to counter the notion that Hazelford Lodge was an institution.

The boundary between Hazelford Lodge and the outside world was closely guarded with the frosted glass front door denying a view inside. The entering visitor could not get far without being noticed, as the Matron's office and residents' toilets, a place of intense staff surveillance, were right beside the door. The toilets often smelt unpleasantly strong and air fresheners were strategically placed throughout the hall. Thus, the initial impression of the home gave a confusing mixture of the homely and the sanitised.

Bracken Court had been purpose built as a nursing home and opened eighteen months before the block observation period began. Approaching the building it had a modern anonymous undomestic exterior and its large glassed lounge and foyer allowed a total view from outside into these areas. The heavy glass swing doors at the front of the building gave the appearance of a hospital entrance. Inside, Bracken Court was carpeted throughout with a 'seconds' flawed carpet. The walls and ceilings were painted magnolia with a few pictures in the lounge and foyer. To the visitor the buzzers, smells of disinfectant, uniforms, trolleys and wheelchairs gave an impression of hospitalisation and a medical order. Also, it was much easier to enter Bracken Court unseen, there seemed to be the anonymity and easy access of the hospital, the swing doors were always open and the foyer often empty.

Section Two: A Description of Space Use in the Homes

In terms of the division of space in Hazelford Lodge¹ there was a basic demarcation between the space of the staff: the office, the kitchen, laundry room and dining hall, and the

¹ Please refer to appendix 2a and 2b for basic plans of Hazelford Lodge and Bracken Court

residents space: the communal lounge, corridors and bedrooms. Although there were some minor differences between staff/resident interactions within different spaces, it seemed that for most residents their perceived typification by workers was far more important in determining their treatment wherever they were in the building. For example, the confused were infantilised strongly in the lounge and in the bedrooms they were infantilised even more.

In Bracken Court nursing home space could loosely be divided into two. Firstly, the public areas: the lounge, foyer, main office and drugs room, these rooms were far more open to public scrutiny than others and were colonised by the trained staff. Secondly, the private areas: bedrooms, bathrooms and corridors, these were work spaces for the auxiliaries. These areas were also hidden spaces, where abject features of life were present: degenerated bodily states, polluting substances, madness and general disarray, these features characterised bedroom space. These states were ordered within the bedroom spaces by the auxiliaries to produce the 'lounge-standard' patient; a clean, orderly and vaguely lucid patient who could be placed into public view without causing offence.

Space management was therefore important to both homes. In order to maintain the image of the well ordered, caring residential or nursing home, it was necessary for the residents' and patients' bodies to be ordered effectively around the homes spaces. Such ordering, signified to others that care was going on.

Description of The Bedrooms

Hazelford Lodge had twenty nine bedrooms, two of which were doubles and the rest singles. During the observation period all the bedrooms were occupied. The bedrooms at Hazelford were routinely painted magnolia, they all had the same floral curtains, blue carpet and ensuite facilities in white. Residents could customise their rooms as they liked, including painting or bringing in furniture. But there was a difference between the appearance of the confused residents' rooms and the more able in terms of levels of personalisation.

Example 1

Hetty suffered from senile dementia. Despite being put in a double room alone she had not colonised the space at all, her room was bare and impersonal with only the basic Hazelford

Lodge furniture. Not only was she not sure where she was most of the time but she had scarcely any objects with which to locate or reassure herself.

Example 2

Some of the more able residents' bedrooms were referred to by workers (rather sarcastically) as 'palaces'. Lucia's room illustrated this label, her family had painted it pink and she had brought in paintings and domestic bedroom furniture. Her bed had its own pink frilly headboard and she slept in expensive sheets. Most residents had colonised their rooms to some extent.

Assistants had little involvement with most residents in their bedrooms. Most residents were fairly able and did not use their call buzzers, thus contact between workers and residents mainly happened in the lounge. The access assistants had to residents' rooms was to service them in the mornings when the residents were in the lounge or having their baths. At these times the bins would be emptied, sides would be polished, toilet paper replaced and sheets and towels changed. It was similar work to the servicing of a hotel room. Confused residents got some contact with staff during personal care tasks in areas such as the toilet. However, even these residents could largely do such tasks for themselves.

In Bracken Court nursing home the thirty two bedrooms were magnolia in colour with cream or brown blankets. Some patients had supplemented this with duvets. The rooms when first taken, were generally bare, furnished with basic white furniture and nursing/care work objects like commodes, hoists and towel trolleys. All rooms had ensuite facilities. Most rooms in the home, with three exceptions, were single and had a variety of levels of customisation by the occupant, with photos, small objects and customised bed linen etc. The three shared rooms were composed of one four-bedded room and two two-bedded rooms, these were inhabited by four women, two women and a married couple. The two doubles were more personalised with patients' belongings. However, the four bed room more closely resembled a ward with little space for personal belongings. It was generally the rooms of the patients whose had been admitted for non-mental conditions that were most individualised.

Most rooms at Bracken Court could be described by the term 'minimal warehousing' used by Evers (1981,116) to express the storage of older people in hospital wards with few of their own possessions. For example, Miriam, a patient who suffered from dementia, had

moved in two weeks before the block research started and had only a television, some photos on the window sill and a small ceramic figure of a robin on a twig. Continued visits to the home showed that even six months after the block observation period her room had not changed considerably and remained bare and impersonal.

The more able patients could expect to spend fourteen to fifteen hours out of twenty four in their bedrooms, the less able up to eighteen, depending on the order that auxiliaries got the patients up and put them to bed. Mornings begin early in the nursing home with patients woken for a drink at about 7am. This period was characterised by a need to wash and deal with a small group of the patients who tended to have mental health problems and incontinence difficulties. This work was all undertaken in the bedrooms. It was customary to present the patients to the new shift intact, clean, and quiet in their rooms for 8pm. Other chores such as tidying up or emptying bins could be left for the next shift but the servicing of bodies seemed to be a task that symbolised the job had been done properly.

The next shift would take over, spending all the morning in the bedrooms, washing and dressing patients. Their exposure to patients was restricted to the demented and very infirm and sick. The workers spent most of the morning getting patients ready then taking them to the lounge, by lunch time they were all down, but straight after lunch it was time to put them back to bed and later get them up again.

Thus the auxiliaries' work could be said to revolve around the bedroom, it was a private world in which they were able to decide the rules. In the evenings work again revolved around the bedrooms as staff got patients ready for bed, and by the time the night shift came on virtually everyone was in bed and the aim of the night auxiliaries seemed to be to keep them there and quiet. At all times the bedrooms seemed restrictive areas for the patients. They were places that were never their own; bare, cramped rooms that they could not leave or enter unless they were taken, that they could be forcibly taken to if they were seen as behaving badly and that were always unlocked.

During the day the bedrooms were often used by the nursing home as storage space for things like trolleys, piles of clean linen, blankets, hoists etc. Also, in the cases of illness or impending death, patients were kept in their rooms or taken to them and acute sickness existed solely in these spaces. Whilst I was at the home only one patient was considered acutely sick and the auxiliaries labelled her 'dying'. Her life consisted of staying in her room and being brought out for meals in the lounge only if her symptoms, choking up phlegm, coughing and her behaviour, crying, sobbing and moaning, were very mild that day. Whenever she came out she was cared for by trained staff and was plainly their property with auxiliaries only allowed near her to lift, and wheel her about.

Other states that only existed in the bedrooms were violent outbursts, shouting, spitting and other anti-social behaviour, continual rapping on tablets, sticks on floors, and also very persistent crying and sobbing. These behaviours were immediately physically confined to the bedrooms by the auxiliaries if they broke out in the lounge. Those patients who were left displayed in the lounge were those who fitted the home's construction of the patient: physically and mentally ordered, dressed tidily, unsmelly and sanitised.

The Lounges

Hazelford Lodge residential home's lounge was a special place for the residents. Unlike their nursing home counterparts they spent much more of their time there, often in communication with others. For the prospective new resident, the lounge was presented as the centre of home life, where residents socialised and an atmosphere of calm presided. There was a decided absence of clutter of zimmers, chairs and other objects to allow easy access.

Residents sat in four main clusters around the room, chatting to those beside them or napping. The lucid residents tended to sit by the door farthest from the windows, the less lucid sat in the bay window directly opposite, where they were open to surveillance from most parts of the room. When the physical chores had been done at least one worker was usually to be found in the lounge 'entertaining' residents with puzzles, card games or dominoes. During morning coffee, mid-afternoon tea or evenings, all the care assistants on

duty tended to converge upon the lounge and chat to the residents for twenty minutes or so. The relaxed atmosphere seemed to put visitors at ease in the lounge. Observation revealed that most day visitors were 'regulars' who were given a special belonging status in the home. 'Regulars' tend to visit the communal areas and the interaction between staff and relatives at times appeared more like that of close friends.

Despite the relaxed atmosphere the lounge had a culturally disjointed physical construction. The walls, as in most of the home, were magnolia but the curtains, carpets and accessories were of a domestic type. However, as an ensemble there was a lack of fit; objects were patterned but not matching and the vases and ornaments were a mixture of expensive Royal Doulton porcelain figures and cheap and cheerful souvenirs. The chairs in the lounge were high backed and institution like, and a few seats had covers on to protect them from urine. The pictures on the walls did convey a fairly consistent message. They were highly stylised pictures of days 'gone by' and quiet life styles such as, country cottages with leafy paths and gardens, pastoral scenes across countryside and mournful Victorian children. In these pictures time stood still, life was quiet and idyllic. On the wall opposite to the window were pictures of staff with residents many of whom who were no longer living. This, along with the pictures described above, served to give an impression of something lost.

Bracken Court's lounge was a large room which looked out over the garden. It had a goldfish bowl quality as it was surrounded by windows and was very bright. The walls of the lounge were painted magnolia as were the corridors and bedrooms, and the same dark blue carpet ran throughout the home. The lounge chairs were particularly unwelcoming, these were large high backed chairs in navy blue, most of which were stained and smelt of urine.

Chairs were formed into clusters, one around the television, another by the door and one in-between. The clusters had the effect of sectioning off separate areas and creating potentially private spaces. Sited in isolation from the clusters there were seats on the edge of the lounge which looked across the garden. Five patients sat in these: one male resident who was violent, three non-communicative stroke victims and a very anxious woman

patient who often wanted attention from the staff. This row was reserved for patients who were highly problematic to care for.

The cluster by the door was a group of female patients all of whom to some extent suffered from the senile dementias. There were five of them in number and their symptoms included: aphasia, occasional shouting, crying, pinching and slapping staff, bashing objects on furniture and withdrawn silence. All of these patients had the further characteristic in common of being 'talkers', as they often mumbled to themselves. Although these patients sat together they were not encouraged by the auxiliaries to talk between themselves.

At the bottom end of the lounge, clustered in varying distances from the television, were the relatively more able. These patients would be left all day to their own devices in the lounge often watching the television or napping. The television elite were all sociable, fairly lucid, compliant, talkative to each other, a social band. They represented the legitimate representation of the nursing home patient. Other lucid residents preferred to stay in their rooms, this was accepted by staff and their attempts to care for themselves were welcomed as long as they saved the auxiliaries time.

The Lounge as a Public Area

The lounge was a public place, there were often visitors around, and their expectation of a nursing home had to be fulfilled. The lounge area was monopolised by the trained staff and Matron which gave it visually a nursing atmosphere. Auxiliaries generally only entered to deposit patients in chairs or collect them. During these times they were under the scrutiny of visitors and trained staff. Trained staff were more gentle in their approach to patients than the auxiliaries, and appeared concerned about the patients mental well being. They took time to comfort patients and were more likely to see crying or physical symptoms as genuine. Auxiliary staff were more likely to ignore crying or depressed talk when exhibited in the lounge, visitors did not criticise these two different ways of dealing with their relatives and largely seemed grateful for any help at all.

The patients with confusion sat at top end of the lounge, farthest from the television and closest to the doorway and toilets. This position allowed an easy access and escape in the case of unacceptable lounge behaviour such as, violent outbursts, masturbating in public and heavy incontinence. It was the auxiliaries who were left to take such patients away after such episodes and discipline, tell them off or change them in less public spaces.

Although generally one could assert that the lounge area was the most open to public scrutiny, the smaller arenas closed off by their high backed chairs allowed some privacy and indeed abuse of privacy. For example, one lunch time I observed Maddie (aux.) feeding a patient with senile dementia. During which she openly referred to the home as "the mental hospital" she also threatened the patient, who was not eating, that she would "push your (the patient's) face in it". This went on adjacent to relatives but sound was largely blocked off by the high backed chairs and loud television. Therefore, there was some potential for overlap of bedroom and lounge auxiliary behaviours.

Staff Spaces

In Hazelford Lodge the kitchen had been colonised as staff space. The kitchen seemed to be a place where the women relaxed, laughed openly and discussed the rest of the home as if it were another place. It was also in this space and the adjoining dining room, that illegal eating and drinking could take place. The office was no good for this because its position, beside the front door, left assistants open to policing and discovery by owners, relatives or residents. The kitchen was a world over which the care assistant could have ultimate control, the sink, the bain marie, toaster and cooker could all be easily managed.

The kitchen was domestic in appearance with mock pine units, these were full of 'extras', foods that were best made or kept on site. These were generally covering substances: gravies, custards, sauces and condiments and items that were best prepared on site: eggs, ice-cream etc. The poor standard food from the nursing home could be hidden with these and the care assistants felt that doing this was necessary to minimise the trouble they got when serving out the food. They joked about the food as not fit for a pig/dog or husband.

A supportive mood was maintained in the kitchen space by the care assistants. It also gave them some space away from the residents. For example, when residents were abusive to staff, the kitchen was the site of the post-mortem of the interaction, where the workers got their stories straight and levelled any blame firmly away from themselves.

Example

Judith (assist.) had a disagreement with Dotty (resid.) who had apparently gone back to her room and fallen over. Once down in the safety of the kitchen Judith gave her account to others;

"That woman's a bitch, I hadn't done anything wrong in the first place and then to go back to her room and play act. When I went in she said she couldn't move, later on Sandy said she had moved herself onto the bed"

Eileen: "We know what she's like nasty mean cow, we've all been at the end of it"

The other staff agreed that Judith had done nothing wrong and that this was typical of Dotty.

Thus, the kitchen had a special role for the care assistants, it remained free of residents and was a refuge. The care assistants were very territorial over this area and had developed strategies to protect it as their own. One of the main ways to maintain an intruder free kitchen was to state the health and safety laws to anyone who looked as if they might possibly cross the threshold. Although it was true that these laws existed they were only applied 'ad hoc', and when the assistants were busy they allowing certain trusted residents to wash up.

One difficulty for the assistants was making sure that newcomers to the home were aware of their space rules. During observation a resident moved in, bringing with her a visiting son who was a 'wanderer'. At the end of one evening shift he walked into the kitchen to be promptly told,

Eileen: "This is the kitchen, people don't come in here, we're always very busy (indignantly and almost accusingly) ... (he exits) ... you don't walk into someone's kitchen, do you?"

Once he left the analysis of this behaviour began. The next day his behaviour was hot news and the assistants explained his behaviour as, "Listening in on conversations." "Barging in." "Taking over." Eventually it was decided that he was "weird" and "probably gay"(Sandy). There was a very strong sense of a boundary violated and a space invaded.

Visitors were never observed in the kitchen area at Hazelford Lodge, it was an unwritten rule between care assistants, visitors and residents, that most chores and certain spaces were purely for the care assistants and were out of bounds to others. The dining room was for most of the time used by the workers but not actively, it was the dividing space between the kitchen and the lounge which gave workers the chance to hear the approach of potential intruders.

Spaces such as the office and the sleeping in room were not colonised by the care assistants. Only official business went on in the office: phoning relatives or services, sometimes writing up events in the communications books, organising the drugs cabinet and its contents etc. The night 'sleeping in' room, with a toilet and ensuite washbasin was sited at the far end of the building. This was not used because of the distance it was from the other areas, staff used the residents toilets. Due to the mobility of the residents and the assistant expectation that residents should walk, corridors and other spaces, unlike in Bracken Court nursing home, were kept clear of trolleys, dirty laundry, people in wheelchairs and other obstacles.

At Bracken Court nursing home the official staff room was a white room with an old carpet, a table, a small kettle, mugs and a small toilet room with mirror. This was to be shared by all staff, which some days could involve ten staff and occasionally visitors sharing the same facilities. The room itself was dirty with an ever overflowing bin, dirty mugs and unclean toilet. On the toilet door there was a message on a scrap of paper it read, "Wash hands, bodily fluids".

Auxiliary and trained staff very rarely used the room, except to leave belongings in it and during shifts the room remained empty. Part of the reason for this was the management ruling that auxiliaries should have their breaks in with the patients and although drinks were made separately in the staff room they still had to be consumed in the lounge. In defiance at their lack of space the auxiliaries had colonised the patients' rooms and would often 'hide' up in the bedrooms drinking the leftover coffee. The bedrooms appeared more the auxiliaries space than the staff room, which left them vulnerable to scrutiny from the owners.

As the staff room was effectively made out of bounds the auxiliaries often did not fulfil their own physical needs. On seven hour shifts they did not eat, sometimes only having a small cup of coffee throughout the whole shift, or did not have time to use the toilet. This tendency to go without appeared to spring from the fear of being caught or being seen as not working. It seemed also part of the workers 'hard culture' where doing the most work possible, even when physically ill, was seen as morally correct.

Auxiliaries at Bracken Court did not spend much time in the other areas such as corridors, stairways, bathrooms and toilets. However, these spaces did seem to serve two functions. Firstly, there was the main function as transportation spaces but secondly, and of more importance, they could be used as storage areas in the process of moving patients or when the behaviour of patients was on the borderline of acceptability. For example, on the top corridor, the lift could take two workers and two patients so it was often decided between auxiliaries to,

Julia: "Do two (patients) in together."

This saved time and allowed auxiliaries to talk together whilst they worked. However, with four auxiliaries working upstairs it often meant there were patients left waiting by the lift to go down. Some patients clearly became agitated and although nursing staff occasionally came along the corridor and witnessed this practice of temporary abandonment, it was not questioned.

The foyer area was used for storing those who were approaching unacceptable lounge behaviour. Visitors were regular and routinised in their visiting patterns, for example, by 11am most had arrived for the morning and this allowed the foyer to be used for storage of quiet unacceptable behaviours, like sobbing. Pippa sat with the demented cluster and for much of the time was quietly sad. However, she very rapidly could become tearful and would demand to be taken home. In these situations she would often be wheeled by auxiliaries, under the instruction of trained staff, to the foyer. Within a few minutes she had usually calmed down to silence, upon which she would be re-integrated with the other patients.

Generally, the closer the area to the lounge the more closely lounge etiquette and rules were observed but this was also related to different times of the day. When relatives were about, interaction in the foyer and corridors became far more like lounge interaction. This was especially true of the bottom corridor which could easily be accessed through the foyer. In the very early mornings, when visitors were not around, it was more like the top corridor and it was common to hear references to bodily substances, madness and sick jokes. Such open references to the abject were more usually heard in bedroom areas.

Section Three: How The Routines Were Enacted Around Space

The routines in the homes reflected the differences in the people being cared for and in the way the cared for were ordered and normalised. Space management was important in creating order and the routines were based upon siting residents in particular places at certain times in accordance with the type of life that the home defined 'residents' or 'patients' should live. Thus, in Hazelford Lodge the resident was expected to spend most of the day in the communal areas and it was important that when visitors were around residents appeared to be actively participating in home life. At Bracken Court control, of both the patients' bodies and minds, was an important work aim, whereas participation was not. At Hazelford Lodge the care assistants were central in creating order and presenting that order to relatives in the home, whereas at Bracken Court the auxiliaries' focus was on creating the patient for the nursing staff to present, they were spatially distinct from the product of their work.

Routine at Hazelford Lodge

Morning for residents was initiated by the entry of the night staff into their rooms and was symbolised in the early morning cup of tea at 7am. For the workers the end of night was signalled by the 'sleeper' getting up at 6.30am and then the story of the night was unfolded by the 'waker' for the 'sleeper' to take in before the cup of tea was served. At night the lone night care assistant filled out a night book, this highlighted certain events and normalised

others as "fine" or "sleeping". Wakefulness, pain, buzzing, wandering and sickness allowed the resident to become individualised within the night book and the accounts given to other staff.

On the tea round at 7am the assistants tended to knock on the residents door and enter straight away. The tone of voice used was maternal, telling residents it was time to wake up, it was the first temporal construction of the residents' day. At 7.30am the breakfast trays were taken up. They were individually made up to residents' preferences stated late the night before. All the residents could feed themselves, and all had the choice of breakfast in their rooms or downstairs. Most residents took breakfast in their rooms. At around 8am the three day staff came on and a very informal change over session began. These sessions were brief and appeared to rely upon workers knowledge of the people at the home and it appeared reports were involved with the continuance of on-going stories. Change over sessions were full of derogatory comments about disliked residents and general complaints.

There was occasional conflict between night and day staff during these sessions, usually over whether patients were putting on symptoms or not. Night workers were more likely to initially view behaviours such as immobility as 'put on' and to voice this in the meeting at the end of their shifts. These workers faced the problems of lifting patients alone and it was from this that their concern about the reality of immobility seemed to arise. For day workers immobility was not so much of a problem, there were three workers on at once.

After breakfast most residents got dressed and made their own way to the lounge. In the first hour most appeared to read the morning papers and were left to their own devices. Meanwhile, the assistants ran baths for those whose names were on the rota for their weekly bath. All women residents' baths were supervised to some extent, even if they were very able. Men were given much more space and given more time alone to wash themselves. If the resident was fairly able the care assistant would leave them "to soak" whilst they cleaned and polished their room. It was this chore which facilitated the informal policing of food items. Workers would check and empty bins, look through drawers and boxes, check

pockets and zimmer frame front pouches and remove old fruit from bowls etc. Rooms would all be thoroughly dusted, sheets changed and the room aired.

Bathing chores with most able residents required cleaning areas they could not reach easily, especially backs. Areas that could smell; armpits and groin areas, were targeted when washing less able and confused residents. Some areas such as feet were often completely missed. Once bathed the resident would either be left to dress or would be dressed and aided downstairs for morning coffee. This was a daily ritual, performed at 10.30am which attracted the regular visitors. Matron or her deputy entertained residents during this break, usually with a crossword, whilst the other care assistants handed out ready made coffees from flasks on the trolley and then wheeled it down the corridors to deliver drinks to some residents rooms.

In the safety of the kitchen area, during the cup and saucer washing, the events of the coffee morning were dissected. Residents' words or behaviour, the socially inept comments of the woman owner, her bad dress sense/singing often led to hilarity. They also talked about the gossip of the home: an assistant's anorexic daughter, how Matron was getting over the recent death of her son and about their own social lives. The kitchen was a 'safe' place, where order was easily created.

After coffee the cups and trolley had to be washed up and the mornings sheets had to be washed. Just before lunch the food trolley had to be collected from Bracken Court wheeled across the garden, the food re-heated in the bain marie and then served 'appropriately' to residents. The chores were divided between the three care assistants on duty and Tina the cleaner, who often helped out in the morning after finishing her chores.

The laundry work was split between two assistants, one of whom would take the larger articles of badly soiled laundry over to Bracken Court after the laundry had all been sorted. Washing had to be graded according to size and extent of soiling before being taken to the larger machines. Small soiled items were dealt with at Hazelford in a laundry room hidden under the backstairs. This room was tiny and smelt of washing powder and acrid urine.

There was only space for one worker, a few laundry baskets and the domestic washing machine. A washbasin sited in a corner could not be reached forcing workers to go through the dining room into the kitchen having touched urine, excrement and blood soiled articles, sometimes without gloves. Wearing gloves did not exempt workers sorting or washing clothes from contamination as they were "cheap and nasty" (Maggie) often with holes or tears, which were only noticeable once workers were literally 'in the thick of it'.

Once sorted into size and extent of soiling one worker would take the large items over to Bracken Court. The care assistant left would load the machine with the ordinary washing and soak and scrub the soiled laundry in plastic buckets. Cleaning materials were rationed to the minimum and there were often shortages. Once the 'ration' was used there were two alternative strategies used to get the work done. Firstly, the assistants could borrow from the nursing home ration and secondly, the assistants could use make-do alternatives. The care staff usually took the latter option using products from the food cupboards such as, salt, sodium bicarbonate and lemon juice to remove blood and dirt.

Whilst one worker scrubbed in the washing room, the other went to Bracken Court. When care assistants entered Bracken Court they were ignored by both trained staff and the auxiliaries. Only the low status staff: the cleaner, the laundry women and the cooks, would acknowledge them. The trolley was wheeled past nursing staff down the bottom corridor to the laundry room. It was staffed by two lilac uniformed laundry women who worked alone alternate weekdays. Fearless and ungloved, they delved into the wash bags to drag out soiled and stained items as if immune to anything they might find there. These women greeted the care assistants and chatted as they helped each other fill machines. I wondered at first how the homes gained information about each other, as they functioned as separate units. I came to the conclusion that it was here, amongst the swapping of the physical dirt of the two homes, that the gossip 'dirt' was also dished out.

Once the sheets were brought back, the same worker would go across to collect the food. In both the residential and nursing home I was surprised at how small the temporal divide was between food work and 'dirty' work. In the residential home this was a stronger theme

because the workers washed and cleaned bodies, dusted rooms and prepared and handled food. Mornings were particularly 'dirty' times, when coffee break and handing out biscuits was often sandwiched between clearing soiled beds and washing bodies.

Mornings were the main times for events in the lounge. These tended to be highly routinised. For example, Monday was nail painting day, Wednesday the hairdresser visited and Thursdays were often chosen by the owner to hold sing-alongs. There were also irregular morning sessions of chair aerobics. These events were designed by the assistants and owners and seemed somewhat forced upon the residents.

Lunch Times and Afternoons

Once the trolley was collected from Bracken Court and the food transferred to the bain marie, residents would be called into lunch. This led to a rush for the dining room which highlighted the importance of food and routine for the residents. Seating order in the lounge was arranged by Matron and staff with an eye to matching 'compatible' residents.

Josie: "We try to sit friends and similar types together for meals."

This appeared to be useful in preventing disruption, especially in keeping the confused, who tended to be disorderly eaters, away from the others residents. Once the meals were given out one assistant would give out the drugs to those who took them at lunch.

After lunch the residents tended to nap in their chairs or in their rooms. This gave assistants time to clean the lunch dishes and eat the leftover food undisturbed in the dining room. Being caught eating leftovers led to instant dismissal if discovered, but it was a daily event in Hazelford Lodge. Staff sat on the cleanest table and served out whatever was left, often eating bizarre combinations piled in bowls. The first to finish would take watch at the kitchen window in case the owners arrived. On my first day I was allowed to watch the others eat and no mention was made of the illegality of eating. On my second and third days I became watch, and after that, I was given a place at the table.

After the kitchen work and eating there were still chores to be finished by the end of shift: ordering the laundry into piles for residents, labelling, ironing or mending. The residents

would awake for the afternoon tea, which was held at around 2.30pm. Workers organised the tea trolley and flasks and it was wheeled for the second time through the lounge, down the bottom corridor and finally to those residents who stayed in their rooms upstairs. Similar to the coffee break relatives often dropped in during tea breaks and crosswords and ritualised chat focused the occasion.

At 3pm the morning shift ended but one full time member of staff stayed on for five minutes to update the new shift. The run up to dinner began at around 3.30pm with the tea break crockery being washed and tables laid. Part of the assistants' job included preparing small items of food for meals and occasionally preparing all of an uncooked meal. Some days this would involve boiling eggs, preparing sandwiches and washing salad food. Most days items such as custard and gravy were cooked and this was used to cover items of food sent over by the nursing home that were badly cooked, small or visually revolting. Indeed, 'patching up' the meals prepared by the cooks took up a good deal of kitchen work time.

For the residents evening began after dinner. *Most residents stayed up until around 9pm* and despite the existence of a television lounge, it was never observed in use and entertainment appeared restricted to chatter or game playing. Dominoes and scrabble were often played in the evenings with some of the more able residents helping the less able. Early evenings for workers were quiet allowing ironing, sewing and talking chores to be undertaken. At about 8pm the confused residents were helped to bed and at 9pm, the bedtime drinks were taken around. This appeared to mark an unofficial watershed for visiting, and anyone other than staff and residents in the home beyond this point were constructed as disruptive. Assistants used certain techniques to get rid of these visitors. A common way was for staff to constantly interrupt conversations or to bustle about jangling keys until the visitor left.

Whilst drinks were being consumed one assistant would fill out the drugs and communications books. These were supposed to be filled out as residents were given their drugs or when incidents occurred. However, evening shifts always finished with the events

of the day being reconstructed from memory and the stories being relayed to night staff when they came in. At 10pm the evening staff left.

Nights

There were two members of staff on at night: a sleeper and a waker. The sleeper's role was to back up the waker and help with heavy tasks or in emergencies. However, to wake the sleeper was seen as thoughtless, unless there was a death or an emergency. There were two stages to nights for night workers. Firstly, the early stage when the sleeper was still up and helped to get the morning trays organised and secondly, when the sleeper retired at 11pm and the waker worked alone.

When the sleeper went to bed the reality of night work as scary and frightening, yet at the same time monotonous, was revealed. Workers described loneliness and,

Hilary: (NS. Interview data) "Corridors that stretch out endlessly in front of you."

Dark parts of the home which were exposed to the outside such as, beside the glass door at the end of the bottom corridor and by the large uncurtained windows near the laundry room, were rushed through. The fear of the outside was paramount but also there was the fear of the inside; of discovery of bodies instead of people in the bedrooms and being alone in the dark with corpses.

The night was mapped out for the lone wakers by two hourly rounds. These involved listening at doors and looking in on the sick or confused. Night workers often helped residents to the toilet during rounds but discovery of soiling was rare. A lot of night work entailed providing comfort and company to the residents. The wakers knew extraordinary information about the residents' lives which other workers did not know. Suicide attempts and miscarriage stories were revealed in conversations at night. This information was treated as private secrets between the assistant and the residents and I felt privileged to be told about them. Night workers were also adept at comfort remedies: talking, cups of tea or hot milk, hot water bottles etc. and were flexible in their care. Working alone seemed to make them more eclectic in method.

At 6.30am the waker woke the sleeper and they had breakfast during which the story of the night would be told. Following this, at around 7am, the tea round began. This was a noisy business, the trolley rattled continually and the assistants seemed to ignore that others were sleeping. On two mornings I observed night workers singing loudly as they walked down the corridor and they tended to burst into rooms with a brisk and jolly greeting rather than a knock on the door.

Once in the room worker behaviour was extremely loud and they awoke residents by leaning over them and loudly calling their names. Doing the tea trolley and then taking the breakfast trays to residents were the last chores for the night workers and this exuberance seemed to arise from that fact as Kath (NS) noted,

"At the end of the shift you start waking up because you're glad to be going home."

The night workers though, seemed to enjoy their job with all the regular wakers commenting they would rather do nights than days.

At quarter to eight one assistant would arrive and was told about the night shift. Fifteen minutes later two more assistants joined her and the night workers left, she then retold the night story for them. At times this chain of information seemed like a game of Chinese whispers in which stories developed, and unknown details were filled in by reference to the residents' usual behaviour. After the information was shared out the empty trays were collected and some residents would be served breakfast downstairs. The morning rituals then began again.

The Routine At Bracken Court

The morning auxiliaries arrived at 8am and begin sitting patients up for breakfast and toileting them. As Lucy noted;

"Our main work in the early mornings is to get them sat up and washed."

The first patients to be 'done' were those in the four bedded room who were heavy and immobile. Two auxiliaries would then go to the kitchen to take around the breakfast trays, the other two workers being left to continue sitting patients up. By 9am all patients had been seen by at least one auxiliary and each worker could on average be expected to aid

about four residents at this stage in the morning to feed themselves or with some other chore. At 9am there was a report session in the Matron's office lasting approximately twenty minutes, during this period work ceased and surprisingly buzzers were rarely answered.

After report, dressing, washing and bathing began. Although all patients had some help with bathing, some dressed themselves and insisted on staying in their rooms, a practice that was accepted. Auxiliaries bathed patients in accordance to whether it was their bath day or if they were badly soiled, general washes were undertaken daily. The auxiliaries worked in pairs in areas allotted to them by the Matron; the home was divided into three main areas, the downstairs corridor and the top corridor (which was split into two). Work was negotiated between the two workers paired up together. Occasionally auxiliaries were paired with Enrolled Nurses or very occasionally RGNs, in these situations the trained member of staff seemed to take responsibility for the ordering of care. When working on individual patients auxiliaries would generally work alone except if the patient had very poor mobility or was physically heavy. The larger the patient the more likely that the partners would work together on the care task.

Washing and bathing were functional pursuits rather than being an enjoyable experience for residents. Patients were washed mainly in bodily areas likely to smell such as, armpits and groin regions. Washing, dressing and bathing took most of the morning, once dressed, patients had their hair combed and women often had their faces made up with cosmetics. Most patients would then be wheeled down the corridors to the lounge and a small minority would walk down supported by auxiliaries or alone. The few very able patients generally stayed in their rooms, watching television or reading. Patients were treated and talked about as work objects and auxiliaries spoke about having "done him/her" and about, "doing X" next, reinforcing a notion of conveyor belt care.

Morning coffee was served at 10.45am in the lounge. The tea and coffee, similar to the practice at Hazelford, was served out of thermos flasks on the trolley but it was generally served by the trained staff. The auxiliaries then took the trolley along the bottom corridor

and finally upstairs to serve those in their rooms. The ends of the coffee were drunk upstairs by the auxiliaries and as this was 'illegal' they often hid in the patient's rooms.

At about twelve the run up to lunch began. This involved the toileting of patients who were still partially continent and the emptying of the urine bags of those who were catheterised. One by one patients were lifted, wheeled or helped, mainly by the auxiliaries, to the downstairs toilets beside the dining hall door. Toileting took time and continued right up to the meal being served (a process of about 20-30 minutes).

Lunch was served in two rooms; the lounge and the dining room. The patients in the lounge were often fed their food by auxiliaries and were described as the 'messy eaters'. Feeding tasks allowed the auxiliaries to joke to each other as they worked. Many patients would not eat and so cajoling was used, this involved telling mistruths or blackmailing the patient into eating. For example, an auxiliary might invoke the name of the patients' spouse or children, or say that if food was not eaten the auxiliary would be in trouble. Another method of getting patients to eat involved distracting the attention of the patient then pushing the spoon into their mouth. These methods were distinctly different to those used by trained nursing staff who appeared less successful, they tended to do a lot of talking to the patient asking why they would not eat. Auxiliaries were usually joined by regular visitors who fed their relatives, within this setting auxiliaries openly spoke to the patients as children but relatives seemed uncritical. Many relatives had cared for their patients for sometime and seemed grateful for any help.

In the dining room food was served up by the cook through a service hatch for the auxiliaries to distribute. Patients sat on four trestle tables, which appeared to group them into three. Firstly, the problematic patients who tended to moan about the food, cried a lot, were confused or annoyed the staff, were sat by the service hatch. Secondly, on a table brightly lit by sunlight, sat a group of middle class mentally able women, the verbal interaction on this table was the most energetic. Thirdly, there were two other tables that appeared to seat patients who were mentally able, could feed themselves and were not acutely sick. Some effort was made to seat friends and couples together, resulting in a

crossover of groups. Nobody ever changed tables during the observation and in the case of death the space was left until someone moved in to fill it or perhaps an able patient degenerated.

Afternoons

After lunch furious activity began with workers putting the patients (whose "bums were sore") to bed. Some patients did not go to bed in the early afternoon but sat in the lounge and napped. These patients were generally the non-disruptive and behaviours such as, shouting, swearing, bashing cutlery or aggressiveness could result in removal from the lounge.

All the auxiliaries were involved in the process of moving patients to rooms, but the RGNs tended to help out only marginally, mainly dealing with the paper work in the office. However, enrolled nurses were involved with this task and it was this group of trained nursing staff with whom the auxiliaries had the most contact. The process of transporting patients from the lounge to their rooms was long and arduous. Despite this, the sole objective of the exercise was to get the patient quickly to their destination and often fully clothed into the bed. The whole process was finished by 2pm.

At 2.30pm the new shift of auxiliaries and trained staff came in and began work with a report from the nurse in charge that day. From there they went straight into sorting and putting away the laundry. At 3pm auxiliaries began to get people up and back down to the lounge for tea break. The trained staff, other than enrolled nurses, generally stayed on the bottom floors mainly in the drugs room, the Matron's office and the lounge. In this sense the corridors, and patient's rooms became the domain of the auxiliaries who were in the continual process of moving objects: bodies, trolleys, chairs, laundry bags back and forward to order.

Similar to the process of morning coffee, afternoon tea was prepared and put into thermos flasks on the trolley along with beakers and various appliances for those who could not drink in the normal manner. The trolley was wheeled by auxiliaries into the lounge and

once tea was served the trolley left for the corridors. There were always some patients who stayed in their rooms during coffee and tea breaks and others whose behaviour was deemed unfit for lounge standard behaviour by the trained staff. Auxiliaries accepted that lucid patients might wish to stay in their rooms because of the confused patients who used the lounge. It was common to hear auxiliaries joke and refer to the home as an institution, "Bracken Court mental hospital" and "prisoner cell block Bracken Court". This indicated the auxiliaries' understanding that the behaviour of some of the patients was socially offensive and threatening.

All the nursing staff generally had a separate 'illegal' tea break after patients at 4pm. Staff were officially only allowed to spend tea breaks in with the patients in the lounge but this break was always taken in Matron's office. It was in these tea breaks that more informal chatter would go on between ranks. There was often talk of career plans, nurse training, other positions seen in papers, criticism of trained staff who were not there and discussion of patients' behaviours. This was one of the few times that auxiliaries allowed trained staff to see them taking a break.

When staff tea break ended the build up to dinner began with the toileting and the manoeuvring of patients into the dining room. The lounge-eaters had to be bibbed and their food often mashed up, food had to be handed out and then the feeding in the lounge could begin.

Straight after dinner the process of wheeling patients back to their rooms began again. The disruptive patients with confusion tended to be put to bed first. These patients were usually put to bed by auxiliaries as trained staff were busy, this meant it was auxiliaries who usually received the physical aggression in the evenings. During 'putting to bed' one auxiliary would often hold the patient down, whilst the other undressed them, this was seen as funny by auxiliaries who would boast about bruises suffered. By 8.30pm most patients were in bed and the pace of work slowed. It was only during these times that I observed auxiliaries attempting to spend some individual time with patients. However, the only patients they tended to sit and talk with were the very confused.

Nights

Night Auxiliaries arrived for work at 9pm, usually already fatigued. On arrival it was common practice for night auxiliaries to discuss the sleepless days, naughty and noisy children, chores to be done on arriving home and deprivation of rest they had endured that day. The auxiliaries appeared to try and outdo each others deprivation stories and thus they had a myth like quality. Night auxiliaries were highly cynical about most patients and other staff, maintaining that they were the hardest workers. 'Hardness' appeared to involve a 'macho' notion of being able to cope with tough conditions but also to be worldly wise and less likely to be taken in by patients' false symptoms.

Work began with the staff on night duty, two night auxiliaries and a trained nurse, receiving a report from the nurse in charge from the afternoon shift. Gaining information was highly problematic for the auxiliaries as they tended to be very part-time and the state of patients could change quickly. Thus they were likely to arrive unaware of these changes and the auxiliaries were reliant upon other night workers to fill in the gaps. In the official report little detail was given to help them do this and most night auxiliaries noted to me that there were communication problems.

The first chore for the auxiliaries was to get those patients left in the lounge to bed. This involved wheeling people back and forward in wheelchairs, lifting, washing and undressing them. The characteristics of the patients at night had often radically changed from those seen in the day, they attained a state of being "out of it" (June, NS). They were groggy (often from medications), irritable, even more immobile than usual and difficult to transport. They were less likely to be able to help the workers get them out of bed and onto the commode or help with undressing themselves. On the eleven hour night shift much of the auxiliaries' time was spent downstairs but when she undertook a chore, a higher level of effort, time and strength was needed to deal with patients than for day shifts.

Once the patients were all upstairs the auxiliaries helped the very incapable to undress. Other more able patients would buzz for assistance and those able patients who were

considered bossy would be made to wait until last for help. There was an idea amongst auxiliaries that patients played games with staff. For example use of the call buzzer was interpreted as an attempt to 'wind up' or get at the auxiliaries.

By about 11pm all patients were in bed and the auxiliaries settled themselves into the lounge. This involved moving their belongings from the staff room to the front room, finding a chair (that did not usually have an incontinent patient in it during the day) and sniffing and patting the chair to check. Most auxiliaries and trained staff read, knitted or napped through the night but the trained staff tended to sleep more than the auxiliary staff and usually left auxiliaries to answer the buzzers and do the rounds.

Every two hours rounds were undertaken. They involved a highly ritualised routine, which revolved purely around servicing the patients' bodies. They started along the bottom corridor and worked their way upstairs through each room. The main chore was to check the continence of the patient, this was an invasive procedure.

Example (From field diary, 5/3/93)

"The same ritual is observed in each room entered, the auxiliaries go in alone or in pairs. The toilet light is switched on, a jug is collected from the toilet, the patients bed sheets are pulled back exposing them to the air, their night clothes are pulled up to allow the leg bag to be emptied, they might also be rolled over to allow access. The urine is then thrown down the toilet, which is flushed, the jug is washed, the sheets are pulled back over the patient and the auxiliary exits. If a patient should stir or open their eyes during this ritual they are told to go back to sleep. Many patients lie motionless with their eyes open, staring blankly as this process is performed (every two hours). Their presence is not acknowledged."

This was the format of all rounds, irrelevant to which staff were on duty.

At 4 a.m. the breakfast trays were laid out for the morning and the tea trolley was readied for early morning tea at ten to seven. Throughout the night the buzzers rang, most nights only one every half hour but on some nights there were much more and often they were clustered together, which provided extra strain to workers. However, it was seen as acceptable by staff for patients to ask for things, like to go to the toilet, once the tea round was over. It seemed that at this point morning officially began and buzzing was expected. The morning staff came in at 7.45am and by a few minutes to 8am the night auxiliaries began hovering around the main door, on the dot of 8am they left.

Section Four: A Discussion of Space Use In The Homes

There was a difference between the settings in the focus of life of the homes and the ownership by residents and staff of space. Within Hazelford Lodge the bedrooms functioned largely as the residents' private space. The care assistants entered them to service the rooms once a week, to help with small chores like cutting nails or to give out tea or coffee at various points in the day. As most residents were lucid they could care for their own bodies and there was no real justification for entry. Bedroom work reduced the care assistant to housekeeper or possibly hotel maid: cleaning and polishing, emptying bins, changing linen etc. Workers tended to view the over use of this form of private space as an obstacle to care and residents were encouraged to use communal space.

The main communal space in Hazelford Lodge was the lounge and most work was lounge work. Residents were loosely ordered in the lounge into groups with compatible physical, mental and social groupings, by the workers. Thus, the lucid mainly sat to the right opposite the window. Those that sat in the bay window were all considered confused and/or the sick, their lives were ordered for them, and they looked out towards Bracken Court, as if pre-viewing their fate. The bay window area bathed in full light allowed full surveillance from all angles thus preventing anything 'illegal' being done without workers or other residents being able to see.

After the basic ordering of the resident and assessment of their correct grouping, most lounge work for the care assistant involved the presentation of residents to visitors and entertainment in the lounge area. Work did involve taking people to the toilet but it was mainly talking work, involving the residents in crosswords, scrabble, gentle discussion, especially when the owner or relatives were around. In between being entertained and talked to, residents were left to sleep or knit.

In comparison Bracken Court's view to the visitor was characterised by its openness to the outside and the strict spatial divisions within. Many patient bedrooms represented the order and imagery of the nursing home; being furnished only with home furniture. Some rooms were commandeered to store nursing equipment thus emphasising further the iconography of bodily care: hoists, trolleys full of pads and towels, nursing instruments etc. Within this setting, the patient as individual became invisible.

Inner regions such as the corridors and stairwells that led off to the upstairs bedrooms, the treatment room and kitchen were guarded by auxiliary staff. The external boundary was not as important in Bracken Court as the internal borders and the work of boundary maintenance seemed to be similar to a hospital setting, with a focus on public and private areas and tasks. Possibly this was because the patients were generally incontinent, confused, with disordered and visibly degenerating bodies. The establishment of firm boundaries within the home was necessary to prevent visitors viewing the disorder which was expected to be controlled within this setting.

Bracken Court's auxiliaries mainly worked in, and colonised, the patient's bedrooms. In this space the nursing auxiliaries attained the product (and proof) of care, the 'lounge standard patient'. This was done through work which could be construed as similar to Goffman's (1959,126) backstage "technical" work: they cleaned, dressed, and disciplined patients. After this process they could be taken to the lounge. Lounge space and work was higher status, the lounge being a more visible place and the work involving the "expressive" (1959,126) labour of presenting the sanitised individual to others. In comparison, bedroom work and auxiliary work was hidden and entailed the organisation and processing of the body and dirt, which in Western society is usually seen as highly private.

Thus, Bracken Court's bedroom worlds doubled as work places for auxiliaries and did not constitute a truly private world for patients. Bedrooms were characterised by their hidden nature as spaces, the mechanisms of the processing of patients was unseen to outsiders. The secrecy of the bedroom space and job allowed the lounge to appear to be the only form of order in the home. The lounge was presented by the recognisable and legitimate

uniforms and discourse of nursing and was inhabited by the 'lounge standard' patient: unsoiled, preened patients, with teeth in, hair brushed and earrings as appropriate to gender, looking lucid. The nursing staff, who characterised and colonised this space, were the workers whose image was deemed acceptable to present the standards produced by the auxiliaries, who may be considered as their underlings.

In Hazelford Lodge the staff had colonised the kitchen and dining room area as private places for themselves. Encroaching on resident space was not an option as the residents were capable of complaining. It was also used as a leisure space and a retreat from the rest of the home: staff not only discussed the behaviours of residents here, but also supported each other when abused by residents, laughed at the owner and discussed their private lives. Their pattern of colonisation of home space reflected space used traditionally by women in the domestic world (see Craik 1989).

Space and its organisation was an important part of the auxiliary and care assistant work. In Bracken Court nursing home the organisation of space was visually a conveyor belt like process, and the physical features of the settings were bleak and institution-like. Within this context bodies were processed, dressed up and placed in certain spaces: the lounge, dining room, toilet etc. Many of the patients displayed features which are socially unacceptable in Western society: mental illness, overt physical degeneration, uncontrolled bodily dirt. The ordering of these features was done in the 'private' space of the patient's bedroom and was the central form and place of work for the nursing auxiliaries.

Although in Hazelford Lodge residential home the decor was more domestic than that of Bracken Court, its institutionalisation remained in the mixture of domestic styles throughout. The care assistants, like the auxiliaries, were deprived of a usable space of their own but had taken over spaces traditionally associated as women's space in the domestic home. In this space work and leisure were blurred, it was a place to relax and talk. The capabilities of the residents at Hazelford Lodge meant that bodies could not be ordered around space as in the nursing home, and even the most confused and immobile were not rushed or manoeuvred around in the same way. Thus the method of moving residents

around the space of the home had to convince them to order themselves in and around the setting.

The Closeness of The Settings

The two homes were interrelated not only in their physical adjacency but through the way work was organised between them. They largely functioned separately, but at certain times of the day the nursing home was used as a resource by the residential home. Thus certain resources were shared and occasionally the nursing skills of the trained staff from Bracken Court would be utilised. Ultimately, many residents experienced the move across to the nursing home; being wheeled across the garden and given over to the trained staff on the 'other side'. In this way Hazelford Lodge and Bracken Court were potentially jointly responsible for the processing of the individual, often from the point of leaving the domestic home to death. Most homes probably do not experience such a closeness with another setting. Nevertheless, it is not abnormal to find residential and nursing care for elderly people existing in close proximity, and processing clientele between them more generally.

The settings studied also shared the same owners, who had a number of elderly care homes in the South West. Neither of the owners were trained in nursing, medicine or social work, but had backgrounds in industry and teaching. These people did affect care as they were often around and saw their jobs as partially to oversee care and to help hire and fire workers. The woman owner, a trained primary school teacher, was particularly vocal about her view of homes, she spoke of Hazelford as her 'good' home, noting it had a 'cosy family atmosphere'. But she was unhappy about Bracken Court, and expressed a dislike of nursing care, saying she wished it were more like Hazelford.

The female owner reinforced the notion that the residents were childlike and needed protection. However, her effect on the format of care should not be overestimated as in both settings she was generally disliked and derided. Even at Hazelford her presence was greeted with a change in assistant behaviour and the assistants largely saw the owners as

exploitative. It appeared that the form of care in Hazelford Lodge was already constructed on a familial basis, and it was largely accidental that she agreed with that.

The criticisms the owners levelled at Bracken Court focused upon the conduct of the auxiliaries who, they argued, were "lazy" and 'hid' in the bedrooms. It was unsurprising that under this form of criticism and given the poor conditions of work, that the owners were treated with far more contempt at Bracken Court than at Hazelford. Strangely, although the media has focused upon the unscrupulous owner as the cause of bad practice, there has been no sociological research about the attitudes of home owners and the effect of this upon care.

Conclusions

Both the care assistants and nursing auxiliaries used the space of the homes as a resource around which to order the residents or patients and to create unofficial spaces for themselves. Ideas around the form that control and order take in different spaces in the homes, the ownership of space, and the way that residents become patients and are moved on, are important themes in the following chapters about work in the homes.

The last two chapters have presented the homes in comparison to each other in terms of the social and the physical features. The next chapters deal with the work of the care assistants and nursing auxiliaries in separation, presenting data and themes arising out of their work.

CHAPTER FIVE: THE CARE ASSISTANTS' WORK AT HAZELFORD

LODGE

Section One: Disciplining the Inside of the Home

The care assistants' job was, according to the job description, all embracing. Workers could be expected to undertake house keeping tasks, basic cooking and laundry, organise events in and outside the home, escort people to family or the doctor's surgery and negotiate with residents during disagreements. Also they were expected to mediate with external bodies including, funeral directors, relatives, community nurses and social workers, as well as undertake physical bodily care tasks with some residents. The tasks involved housekeeping in its broadest sense.

Part of this work involved substantial verbal assessment and the ordering of residents into 'compatible' groups. Ordering the occupants of the home was important. Firstly, because due to the numbers of residents there was a potential for disagreements and quarrels, and therefore a social ordering was necessary and needed to be continually assessed. Secondly, as the residents were seen as potentially at risk from negative bodily and mental change, ordering was also useful in terms of monitoring the state of the body. This work involved surveillance, discussion between workers and constant evaluation and was organised through the routine, around the space of the home.

Ordering Spaces: The Lounge Job

The lounge presented the care workers with particular order and presentation problems. The lounge area had to cater for residents with a variety of physical and mental conditions, at the same time it was the main arena for the entertainment of visitors. Somehow, the 'difficult' cases, those who were incontinent, incapable and potentially threatening to the able and visitors, had to be presented as order-able, and in a way that would create sympathy rather than objection from others. The care assistants created discipline in this area by encouraging familial-type relationships and normalising the very

frail residents through infantilisation. Thus the lounge job involved the ordering of social relationships through strict control of the format of interactions.

Entertainment as Care

Interaction between workers and residents, was mainly built around the ritual times when they met around food and drink. Firstly, there was morning coffee, then afternoon tea and during a small space of time in the late afternoon and in the evenings, there was some time to talk and play board games. The lounge was the main area in which the care assistants had contact with both residents and their visitors, and within this context talk and entertainment appeared to symbolise caring.

Entertainment chores, despite appearing to be enjoyable to undertake, were still work for the care assistants and were highly repetitive and routinised. For example, the crosswords from the local paper were used by assistants to focus interest within the lounge everyday. Also the weather was discussed in minute detail, often with updates every ten to fifteen minutes. Initially I was stunned by the interest shown in the weather, especially as most of the residents did not venture outside. The subject appeared to have a ritual quality with the actual state of the weather having little importance. For some residents references to the weather appeared to reassure them that the world existed beyond the home. When visitors were around and these main topics ran out the assistants rushed to begin conversations about the news, demonstrate chair exercises or talk about their families. In this way, talk in the lounge seemed highly staged and ordered.

Over-Familiarity

Life in the lounge appeared over-communal and the boundaries of normal conversation were breached. For example, the state of some individuals bodies became a subject for the assessment and interest of all.

"It struck me how wholly private matters become public knowledge in the home and the public/private divisions melted. But this only happened around the discussion of certain residents. So "Do you want a wee?" or "Nice bath?" were things said only to confused residents and often in front of the other residents."(Field Diary Extract, September 18, 1992)

For the confused and sick, questions such as those above appeared directly infantising, and the answers to such questions were treated like common-knowledge. Although the confused resident could expect such treatment also in their bedrooms, within the lounge there was the added dimension of the broadcasting of embarrassing issues to others.

This type of experience of a total lack of privacy could be compared to the cases of other non-confused residents whose problems were treated with discretion in the lounge.

Example

Letty and Dotty both 'leaked' urine and the use of concealment when dealing with their conditions was seen as important by workers.

Karen: "Often I have to sneak her (Letty's) cushions away to be cleaned, I don't say anything it may offend her." Dotty's incontinence was also dealt with in a quiet and discreet manner.

Confused residents did not appear to be considered easily offend-able. The soiling habits and personal habits of these residents were normalised, and in a sense they were made the babies of the home.

Hazelford Lodge's visitors tended to involve themselves with a number of residents, especially the sick and confused, and were encouraged to do so. Unlike in the nursing home private knowledge about individuals was non-existent and visitors were given access to a lot of personal detail about individuals. The assistants constructed the confused as 'sweet' and comical and the visitors tended to view confused behaviour as entertaining.

Lounge interaction revolved around the bodily needs of the sick and confused. They needed taking to the toilet and changing, they were constructed as needing the most directive entertainment and were obliged to participate rather than being given a choice, they needed prompting to have a biscuit, drink their tea etc. and had to be carefully monitored. Their needs, rather than being personal, became the focus of the whole room.

Constant Jovialness

Whilst an over-familiar attitude was maintained towards the bodily needs of the less able residents, generally interaction between staff and all residents was characterised by an over-jovial politeness. Within this, jokes about the weather, puns on other peoples words, weak sexual innuendo and the headlines presided. Higgins (1989,166) notes that the interaction displayed in some homes has been interpreted as similar to that in waiting rooms. Similarly, although assistants and residents in Hazelford Lodge addressed each other by their first names, there appeared to be the forced friendliness of people obliged to meet by fate rather than choice.

Most comments were repetitive and humorous, and evoked the notion of residents as mischievous children. For example, calling residents 'trouble' or 'naughty', teasing them about washing their mouths out/smacking their bottoms etc. were routine jokes. Especially popular were jokes about residents having men/women in their rooms, these appeared to be based on the attitude of assistants that such a situation would be ridiculous. They probably also reflected the social belief that the old are sexless and childlike (Hockey and James,1993,97-99). In return the more lucid residents joked back especially about giving assistants, "a good hiding for their cheek". Part of the assistants' job in controlling the conversation and atmosphere in the lounge involved neutralising potentially threatening issues. However many comments also served to reinforce the residents as less adult-like and less powerful than the workers.

Unlike the nursing home, where the lounge displayed an image of home life that was divorced from that which went on in other areas, Hazelford's lounge served as an accurate representation of the differences in typification, interaction and degree of privacy residents displayed elsewhere in the home.

The Use Of 'Monitors'

The lounge had to be ordered quite strictly when visitors were around. However, there was also a need to keep order when only the residents were in the lounge and workers were doing other things. The diverse abilities of residents was an obstacle to order but

also could be exploited by the assistants as a means to keeping control. When they were not in the room they delegated responsibility for the space to the most trusted and capable residents. This allowed the care assistants to watch and control the lounge without being present.

Monitors were only recruited from residents who were physically fairly able, mentally capable and also compliant. Many took great pride in this role. For example, Nola, who was considered by assistants to be "lovely", often sat in the bay window with the confused, she commented to me,

"Those girls can't be everywhere so I keep an eye on them (other residents)."

Her pride seemed to rest on her selection for this work, also it appeared to allow the more capable to distance themselves from those who were incapable. This role was only used in the lounge, as in other areas such as the dining room the assistants were physically around.

Information given by monitors was often of a moral nature in that it told about something another resident had done or said that assistants would consider inappropriate such as illegal eating in the lounge, bad habits and poor resident hygiene. Monitors were always openly praised for information. The right of the assistants to give monitor status was in itself a way of disciplining and ordering the residents. Monitors were conferred with trust and were given responsibility over a certain space. Thus, residents had the incentive to act appropriately to gain monitor status. Other 'non-lovely' residents who tried to do similar activities to the monitors were constructed in quite a different way. These 'taletellers' did not have the trust of the assistants and were perceived as "sticking their noses in".

The Bedroom Job

Due to the lucidity of the residents, workers had little input into the organisation of bedroom space as most residents in Hazelford Lodge were able to care for themselves. The access assistants had to their rooms was to service it (rather than the residents' bodies) in the mornings when the resident was in the lounge or in the bath. Work in

bedrooms was done alone and included activities such as, emptying the paper bins, polishing sides, replacing toilet paper and sheets and changing linen. It was much more like the servicing of a hotel room.

Interaction In The Bedrooms

Most contact between workers and residents happened in the lounge, except when bringing bring their trays in the morning and the bedtime drinks at night. Residents rarely called assistants to their rooms to give assistance. Those residents that did call staff to their private rooms were those who were judged by assistants to perceive the home as a hotel and their use of call buzzers was a source of annoyance. Despite this, whenever a call buzzer rang assistants ran to the rooms, anticipating an emergency.

For the confused residents there was a different pattern, a lot (but not most) of their interaction time with staff went on in private areas such as, the bedrooms or toilets. Much of the interaction in these areas was centred around care chores, and the format of the conversation was highly infantilised. For example, when one resident was going to the toilet in her room one assistant joked,

Eileen: "Look at that, you're weeing like Barney's bull."

It was common for these interactions to degenerate into a more strongly infantilised version of lounge interaction using slang, childlike, and euphemistic terms for parts of the body.

As the assistants undertook bodily care chores a running commentary was often given of their work which emphasised child-like terms,

Joan: "You've got a dirty bum-bum, lets give it a clean."

Karen: "Right Glenda I'll give your boobies a wash."

Such child-like bodily terminology was not used in the lounge, references to bodily parts were avoided altogether in that setting, but strangely bodily fluids were not. The bedroom areas reflected the patterns of interaction in the lounge areas, except that the typifications were more extreme, the sick were sicker, the confused more childlike, and the lucid given more privacy.

The Kitchen Job

Hazelford's kitchen, similar to the way Craik (1989) describes women's relationships to the domestic kitchen, was a world over which the care worker could have ultimate control. The kitchen was similar to a domestic kitchen in appearance and also in the relaxed behaviour observed within it. Hazelford's kitchen was the only place assistants could legitimately hide in, and for this purpose they coveted it as their own.

The kitchen was also useful for surveillance of the rest of the home as noise from the lounge could be heard, and through its window the front drive and parking spaces could be observed. At mealtimes the service hatch served as a panopticon of the dining room and was particularly well placed to observe the sick and confused table. The analysis of events, support of other assistants and verbal ordering of residents took place within the kitchen space. For example, when residents were abusive to staff, the kitchen was the site of the post-mortem of the interaction and where the blame was levelled away from workers. Also once residents were safely in the lounge the kitchen allowed some sound proofing.

Example

Judith had a disagreement with Dotty who had apparently gone back to her room and fallen over. Once down in the safety of the kitchen Judith gave her account to others; "That woman's a bitch, I hadn't done anything wrong in the first place and then to go back to her room and play act, she said she couldn't move, later on Sandy said she had moved herself up onto the bed."

Eileen "We know what she's like mean cow, we've all been at the end of it."

The other staff agreed that Judith had done nothing wrong and Eileen helped her write an account in the day book.

The kitchen was a special place for the care assistants, for much of the time it remained free of residents, and thus was a retreat.

The dining room was used as a dividing space between the kitchen and the lounge, which gave workers the chance to hear people approaching. During meal times the dining room was divided organised into typification groups: a confused table, a liked resident table, one for the better mannered middle class female residents, one table of men and a few

other mixed tables. Interaction with residents was based around these typification groupings. But for most of the day the dining room was an inactive space.

Spaces such as the office and the sleeping-in room were not colonised by the assistants. The office was too close to the front door and the bottom corridor and thus was vulnerable to both residents or others over-hearing conversations. The sleeping-in room was sited at the far end of the building and also had a ensuite toilet and washbasin. This was supposed to be the staff toilet room but most workers used the residents' toilets, which often were smelly and dirty, but were closer. Corridors and other spaces were used briefly by staff but for their official uses.

Section 2: Family, Mock Kinship Relations and Home

A more sophisticated form of social order was needed in Hazelford to that used at Bracken Court. The work was domestic in nature, it did not have the legitimacy of a nursing structure or discourse. Residents, unlike their patient counterparts were able to complain or leave if they wished and yet somehow had to be ordered around home. The tasks of the care worker were similar to those used in the domestic home, it was involved with cleaning and controlling the environment and ordering the residents' bodies and minds. The framework of caring for and controlling the residents was based upon kinship and domestic forms of work.

Central to the care assistants' rationalisations of their work was the notion that (Eileen) "We are their family". Notions of family and kinship obligations were used to order the home, with the more lucid residents expected to help out with the less capable residents.

As Maggie noted,

"You do think of them as family, I think they could be my mother or for the younger ones, they could be their grandmother. When new people (assistants) come I say that to them, that I look at them as my mother and treat them in a way I'd like her to be treated." (Interview data)

Teresa: "We are an extension of their family and we care for them like our own family."

There seemed a suggestion within the assistants' use of terms such as 'family' and 'home' that these denoted a natural and healthy form of care relationship. However, these workers were not related to those they cared for, and their aims were different. Caring was a way of earning a wage and part of work was to sort those who need other forms of care and process them on. They were also involved in watching for and acting upon degenerative change in the resident in a way not usually seen in the family.

In the residential home larger groups of dependants have to be ordered than in the domestic setting. Hazelford's care assistants ordered residents into typification groups within which the individual became disliked/lovely/sick etc. Using the framework of kin relationships within such a work setting may make the work easier, such a relationship evokes obligations from the carer but more importantly from the cared for. Doing care for strangers is a difficult task. Such constructions may justify the dirty jobs for care assistants. As Karen noted,

"I do for them as I'd do for my mother, I wouldn't like her to be in a state."

However useful and comforting as such a construction is for staff and some residents, it is a subversion of general family and kin relationships for the purpose of ordering the work.

Within the familial construction of the home, emphasis was placed upon doing things as a group. Thus taking morning coffee and afternoon tea was not about refreshment, but appeared to be more about residents showing a willingness to join in. Similarly when one of the group died there seemed a genuine feeling of death of one of their own, even if the resident was disliked.

The workers helped create the iconography of the residential home as similar to the domestic home by bringing in objects from their homes to brighten the building. In terms of internal decor and furnishing the home physically did look like someone's home. This camouflaged nature of the home as the focus of a very detailed, definite and stereotyped, social construction by workers. This created an over colourful, open plan space filled with conflicting images and styles. The homes were physically constructed by workers

on a daily basis with safety, open spaces, creating seating/space for certain typified groups as central. Thus, the residential home was organised with similar aims perhaps to the domestic home with small children in it, the difference lay in the numbers it catered for at a time.

The ideology of family seemed to justify a certain type of care and construction of 'home' within the care discourse. This form of care was constructed by assistants as the best care, one which protected and formed firm social boundaries around residents. But using kinship relations as a framework for care also evokes the darker side of kinship relations such as notions of obligations and the manipulation of love and emotion to gain control. Ideas about doing things in the best interests of residents, protecting them and organising their lives seemed to hide a more sinister side of the care which was involved with getting the work done. The residents lucidity necessitated a more complex form of control than in the nursing home. By evoking family relationships caring behaviours such as cuddling, kissing and the panopticonisation of the residents lives, could be justified as family-style care, rather than as discipline and order.

Ordering With Comfort

The care assistants had a store of remedies for providing residents with comfort, all based on lay notions of care. The main remedies in regular usage were: the cup of tea, a cup of warm milk, two paracetamol, a hot water bottle, a chat and hugs and cuddles. Which remedy was used varied to how the resident reacted to its suggestion. The knowledge and application of comfort remedies were a necessary part of doing good care work and acted as useful control mechanisms for calming and placating residents. Paracetamols, for example, were given routinely when assistants suspected nothing was wrong.

The workers used a narrow band of reasons why residents should need comfort or lay remedies. Common explanations for complaints of illness, restlessness or pain were that residents had eaten too much/too rich food, had been upset by relatives, just wanted company and a sign of caring or were 'playing up'. In each case the treatment would be chosen on the basis of which kept the resident quiet.

The day and night books were the site of the documentation of the application of lay or comfort remedies. A typical entry in the night book which illustrates comfort work read, "Toilet, tea and biscuits - 3am settled back to sleep."

Tea and biscuits was a well used night remedy used by Hazelford staff for sleeplessness. On some nights assistants would try a variety of methods to quieten a resident and whilst in the room a soft approach was used. However, outside swearing and annoyance was commonly observed.

Comment

Thus, the jobs and skills of the care assistants were varied but appeared to often involve an elaboration of domestic skills and roles. Ordering through a domestic format camouflaged control issues through a reassuring facade of caring. The format of caring was based upon the wholesome rhetoric of family relationships which appealed to residents, relatives and visitors alike. But control issues were foremost in maintaining order within the home, and the assistants perceived and spoke about their jobs in terms of the uncertainties of the older body and mind. In order to control, sort and process residents through care, protection, knowledge and a system of typifying residents was needed.

Section Three: Protecting, Constructing and Ordering The Degenerating Resident

The Need for Bodily Order

Elderly people were processed into the home generally through non-medicalised routes and mostly from the domestic home. All the elderly people who were processed into the home were selected for admission informally, rather than through the system of Social Services referral which now exists for Department of Social Security clients. Those admitted tended to have social needs, some physical needs, and fairly few had mental conditions.

However, the workers construction of the reasons for admission emphasised bodily decline and frailty.

Teresa: "They wouldn't be here unless something was wrong with them."

Paula: "There's something wrong with all of them to some degree."

The assistants regarded admission as evidence that old age for these people was problematic and that they were in need of care.

Hockey's (1990) study of one residential home found that residents were divided by workers into typifications of the 'fit' and the 'frail'. In comparison, the care assistants at Hazelford Lodge divided the residents into more than two categories, but all were considered to need constant monitoring:

Teresa: "Any of them could go here anytime with their dodgy tickers ... you could walk into a room and someone could be dead."

Residents' bodies and minds were understood as gradually moving towards degeneration and ill health and many assistants describing the home in similar terms to,

Kath: "The end of the road."

Few residents returned home and much of the assistant's work was centred around preventing the demise of those left.

The Centrality of Protection

Preventing physical or mental decline was focused around ordering and maintaining a balance in the conditions in the environment. In some respects it was similar to the work of the Nightingale nurses, with the emphasis upon the strict monitoring of the home setting. But it was also similar to the domestic labour of parenting and the creation of a safe and balanced environment for a young child. In the case of Hazelford Lodge this ordering was aimed at protecting the frail body from further degeneration. Thus, central heating was maintained at a high temperature, but too much heat was also to be avoided. Windows were rarely opened, noise kept to a minimum, furniture was moved and inner doors left open so as to keep spaces clear.

Control over Emotions

Assistants also maintained a firm control over the balance of emotions in the home and protected residents from what they considered to be psychological stress: over-excitement, upset and change. Emotions were understood by assistants as having an epidemic quality and part of the job was to prevent their spread. This included containing arguments between residents and sometimes disciplining those who were construed as causing disruption.

Example

Edna tended to upset other residents. On one occasion, after she had an argument with another woman who had a serious heart condition, an assistant accosted her.

Julie: "If that lady dies because of you I hope you're sorry, she's very upset now and you know she's got a bad heart, she'll drop dead and you'll be to blame and I wouldn't like to be you having done that."

When residents were abusive to each other it was the assistants who had to negotiate within situations and create a semblance of peace in the communal areas. Being the peacemaker or adjudicator, similar to women's roles as negotiators in the domestic home (Graham, 1985) appeared a major aspect of the care assistants' work. The various emotional methods were eclectically used by the assistants, such as manipulation, confrontation, comforting, bullying and telling white lies, as applicable to the situation.

Emotions such as grief and depression were also understood as epidemic but assistants did not appear confident in their ability to deal with psychological problems. Residents suffering from extended upsetting emotions were often left to cope with these alone in their rooms and the assistants' policy appeared to be to divert their attention away from morose subjects.

Example

Alf had moved to Hazelford after his wife had died, lonely and distressed. He spent little time in communal areas and staff only had contact with him in his room. He was not encouraged to come downstairs as Alf got upset a lot about his wife's death. The prime aim when working in Alf's room was to placate any distress. One morning I observed Judith cleaning in his ensuite bathroom.

Alf: "She was a good wife but now she's gone."

Judith (stops cleaning and puts her head around the door): "Yes, but you've got lots of happy memories, haven't you." (continues cleaning)

Alf: "Yes I have ... I wish she could have spoke at the end." (Cries)

Judith (appears again around the door): "But you were there that's the main thing."

She carried on doing the cleaning chores occasionally answering Alf's comments. Once finished she held his hand for a few minutes, then she left him alone in his room.

Repressing or placating emotion was perceived by the assistants as the best way to deal with extended upset. But failing to respond actively to certain forms of emotion, also appeared a coping strategy. Emotional work took time and expertise, and although workers seemed able and willing to help comfort for short term problems, those which did not react to the usual hug and a cuddle were often contained and avoided.

Protection also involved assistants taking over certain other resident rights which could be construed as symbolic of adulthood. Some of these were stipulated by the owners, for example, parts of residents' financial affairs like pension moneys were organised by the assistants and personal medication was only to be given out by the staff. However, the assistants had extended this protective control. For example, care was often exhibited as pressure to join in events that were considered good for the residents, and when a resident was considered to be generally greedy their room could be secretly raided each week for sweets. These acts were routinely undertaken in the residents' 'best interests'. This perceived need for protection of the elderly was similar to the social view held of other dependent groups. Over protection is part of the disempowering, infantising process exhibited in Western societies in relation to dependant groups, including the elderly (Hockey and James, 1993,9).

Watching and Knowing Bodies

In order to categorise and typify people on the basis of their physical and mental state it was necessary to know bodies and to know minds, this was done in Hazelford through surveillance and was justified as care. The care assistants prided themselves in their knowledge of each resident's body: skin colour, behaviour, breathing and eating patterns, bowel habits and temper. After their weekly bath each resident was weighed by a care assistant. The presence of the care assistant seemed important as they took responsibility for the accurate reading and relating to Matron of the weight, rather than the residents doing this themselves.

The assistants prided themselves on being able to recite the knowledge they had collected about residents. It was a combination of knowing residents and having access to private

rooms at certain points that was pivotal to the assistant's role in predicting or identifying ill health.

Example

Teresa updated me on what had been happening in the home. She described how one resident, Ellie, had been found to be ill:

"We went in with her morning drink and you know how she's very slow in the morning until her first tea, well when we went back in her tea wasn't touched and she hadn't moved so we called the doctor and she'd had a stroke."

Thus, regular contact for basic tasks, like providing drinks, and knowledge of normal behaviour served as checking points when behaviour could be compared to 'normal' behaviour.

Residents who denied access or who spent time alone were constructed as anti-social. However, there seemed to be other issues behind the dislike of privacy. Firstly, lack of access to rooms disallowed the usual observation of the ageing process, so residents who insisted on privacy slowed down and made the work routine more difficult. Secondly, such residents also imbalanced the power of the care assistants by blocking access to knowledge of the body and mind. Residents who insisted on privacy were constructed as wilfully childish and obstructive. For example, Dotty (resid.) had complained when a night assistant had burst into her room having heard noises. Dotty was on the toilet at the time and was angry at the intrusion. Matron apologised but in the discussions in the kitchen Dotty was discussed by assistants as unreasonable and ungrateful.

The care assistants at Hazelford took total responsibility for the measurement, documentation and care of the physical and mental states of residents at the home. On entering Hazelford residents experienced a process of regulation, assessment and ordering of the body and mind that was veiled behind a context of care. In taking responsibility for the residents, the power of the assistants over the minds and bodies of individuals, appeared to be symbolised. Material collected about the individual was used for typifying residents. Firstly, into groups for which chores needed to be done and secondly, to order the boundary between appropriate residential home work and work which needed to be placed elsewhere.

Section 4: Ordering Work and The Individual Through Typification

Residents at Hazelford were constructed as potentially degenerating bodies which had generally lucid minds. A typification system had developed which reflected this dual nature by having two organising features. Firstly the social, this related to perceived personality type, and secondly the physical, which related largely to state of health and mental capabilities. There was some overlap between the two, for example, the liked residents showed the most respect to staff, and were compliant. They also tended to be the most capable.

Typification was a method by which some control could be taken over bodily degeneration and it also gave some distance to the strenuous care relationship for workers. When the individual was admitted they would be fitted into typification groups. Work was ordered on the basis of these existing groups and the type of service they expected. For the resident, the typification work undertaken by assistants was unseen.

Assistants applied sanctions, usually in terms of their time and friendliness towards residents, which presumably were to effect residents' 'choice' of typification. Matron referred jokingly to this as, "training them up". But this appeared ineffective in the case of strong willed residents. Typifications appeared based largely upon the degree of acceptance to, and ability to be controlled by, the care assistants' work discourse.

The established system of typifications of residents at Hazelford allowed an organisation of the boundaries of work and also provided a method for processing residents through them. Typifications were useful as ideal types by which to organise people down the life curve. Eventually, those who were unable to be disciplined within Hazelford's care were moved on. Not all residents took this route, but certain passages existed which could swiftly process all residents to other forms of care: hospitals, nursing homes and secure units.

In order to give some notion of the processing of residents I will initially discuss the main typification groups, beginning with the 'social' categories, which functioned mainly to order and predict work and relationships between workers and residents. Next those categories which related to physical or mental state are examined. These appear to have a stronger role, firstly, in the identification of resident behaviour, and secondly, in the processing of residents into other forms of care. This organisation necessitates some simplification of the overlap of groups and I have placed residents within the master statuses that the workers used.¹ Firstly though, it is necessary to discuss the process of the typification of new admissions.

The Process of Typification

Early typifications of new residents appeared to become set within a few weeks of admission and affected the perception of later behaviour. For example, arrival from hospital or as acutely sick, led to a 'sick' typification. Although it was possible to move from 'well' to 'sick' once in the home, a long period of medically diagnosed ill health was required. Whereas, the 'sick on entry' case appeared to have some permanence. Similarly, confusion as a typification was viewed as permanent.

These examples illustrate the importance of perceived status on admission to later typification.

Example 1

May moved into the residential home from the nursing home. She arrived categorised as sick, but having travelled from nursing home to residential care she was of an indeterminate status. She was categorised as sick but her behaviour was also quiet and mannerly and as there was a gap at the ladies' dining table, she was grouped with them. However, at the end of the first week of her arrival she was caught by Karen running along the corridor carrying her walking frame. The assistants began to keep a more watchful eye on her, however she remained 'sick'. She then began to exhibit signs of being forgetful and was re-categorised as confused. These categorisations reinforced assistant's notions about nursing home patients as "doo la lee" and appeared to give them a sense of order. Eventually, May was sent back to the nursing home.

Example 2

Gloria arrived just after the block of observation. Her son's account aided the assistants in typifying her even before admission.

¹ I confronted the workers with these typification groups to see if they could relate to them, causing some hilarity due to accuracy.

Karen: "He said she's not afraid to speak her mind ... so it looks like we're getting another Dotty."

Eileen: "We'd better get the boxing gloves out!"

Yet, Gloria, like Dotty, was treated with kid gloves from her admission.

Admission status for these two residents was an essential component of their typification as residents. In May's case she was affected by the unnaturalness of her move, Gloria was identified as the type that would not accept poor service. Typifying the residents and selecting those who would mix together the best, lessened the potential for disruption and made the work easier.

Social Typification Groups:

The Disliked

There were three residents who were highly disliked by all staff: two women and, to a lesser extent, one man. Much of the kitchen and office conversation centred around verbal accounts of these people's behaviour. It was made clear to me when I first began observation that these were residents with whom I should not associate.

Jackie: "There's only three (difficult residents) in the home now, but she's (Dotty) the worse, the others are Edna and Ron."

Wherever possible, the day was arranged to keep these residents amiable.

The disliked had features in common. Firstly, they were all *compos mentis*, although they suffered from chronic conditions were fiercely single minded about caring for themselves. All three took an active role in the treatment of their conditions by demanding their drugs on time, checking dosages and by keeping in close contact with their General Practitioners. They also had outside interests to the home which was considered by assistants as unusual. Ron for example, needed help to get dressed in the morning due to a chest problem. He placed a lot of importance on time and punctuality as his medication needed to be taken regularly, which he interpreted to mean at exactly the same time each day. As a consequence he often rang on the call bell to 'remind' staff.

Julie: "When we go into his room he's always looking at his watch."

The assistants appeared insulted by Ron's attempts to control his own care.

There were four main reasons for dislike of residents. The first focused on the type of relationships the disliked residents had with assistants and type of chores they expected the workers to do. The disliked were seen as critical and ungrateful for their care,

Kath: "He's (Ron) a rude little man, no please or thank you and never by your first name."

A Saturday worker, Clara, noted about Dotty:

"She's so critical, when you fill her milk jug its got to be so full or else."

These needs were constructed by workers as unreasonable and designed to belittle them. Also, the residents appeared to consider themselves as customers, thus empowering themselves and disempowering the assistants.

This point links into the second criticism of the disliked, the assistants argued that they demanded a good service without any consideration of the constraints upon the assistants. Disliked residents did not expect to be served on chipped plates, punctuality was important, the call buzzer was there to be used and it was to be answered quickly, all of these expectations were seen by assistants as time-wasting.

Thirdly, the disliked were viewed as a source of disruption. For example, disliked residents were unafraid of having rows with other residents or complaining about care. They were viewed by staff as bullies who picked on the weaker residents. Thus, disliked residents' behaviour made the care assistants peacekeeping and negotiation role more necessary and difficult. In the case of the disliked female residents, argumentative behaviour was seen as particularly malicious, and in private the assistants called them names such as old bag/bitch or witch.

Lastly, all of the disliked residents were considered to have a tendency towards malingering. This made the job of identifying legitimate illness more difficult. For example, the disliked often worried about and monitored their own health and would demand the doctor out even when the assistants were not convinced they were ill. The assistants felt that this made them look incompetent and fussy when nothing was found to be wrong. In the public spaces, or their own bedroom space, these residents appeared to

have more power over the assistants than others, but in the privacy of the assistants' spaces they were derided and their symptoms mimicked. For example, Ron's respiratory problems, despite being medically legitimated, were comically imitated in the kitchen with wheezy breathing and a slow awkward step.

It appeared that the disliked resident wanted to order the environment around them and take control of their relationships, space and care. They also claimed the right to lose their tempers with others and to complain. For the care assistants the exercise of these rights was highly problematic. However, these residents did get a better service from the staff than others. They were served the best quality food, their beverages were on time and hot and although interaction time was shorter and more formal, assistants did not strongly infantise these residents when they spoke to them. The relationships the disliked patients had with staff were similar to hotel guests and employees. They tipped the care workers power game to their own advantage and did not accept the infantising emotional work of the care assistants. They would not be cared for, controlled or be the good resident.

The Lovelies

Seven residents, two men and five women in Hazelford Lodge were regularly and exclusively described as 'lovely' by assistants. Loveliness appeared to involve being seen as good natured, supportive and compliant to the assistants' wishes.

Joan: "She's lovely Nola, she never complains and the little bald man Seth, he's a love."

Being labelled as a 'lovely' seemed the highest accolade a resident could obtain. Lovelies were all fairly physically and totally mentally fit, they required very little personal care. They were the participants in the home, made full use of the communal areas during the day and showed interest in social activities. Lovelies often volunteered to help staff with basic chores like laying the table for dinner and also watched the confused and sick for the assistants. They were model residents and the polar opposites to the disliked.

Lovelies got more contact with the assistants than the disliked and were treated more as adults than confused residents. They were supportive of the care workers jobs

complementing them and often criticised the disliked residents. They were very similar to Evers' (1981,118-120) construction of the 'Dear Old Gran' in the geriatric ward, but at Hazelford Lodge the lovely category was gender neutral.

Another one of the lovelies' main features was that they "liked a laugh" (Kath). Humour and general cheeriness was very important to the careworkers and understanding of the good worker was also positively sanctioned as resident behaviour. In the communal areas lovelies helped keep the interaction going, making jokes about ritual subjects and lightly teasing the assistants. Thus lovelies were useful in helping to maintain order in the home.

Monitors and Tale Telling

Being physically and mentally capable and also compliant, lovely residents were chosen by assistants to act as monitors and to feed back information on the less able. Information was often of a moral nature in and was often about something another resident had done or said that workers would consider inappropriate.

Example

Nola, a lovely resident, often volunteered information about Blanche, a confused resident, who due to diabetes was not allowed some foods.

Nola: "Sandy was doing her blood (test) a few days ago and as soon as she walked away she opened her mouth and there was a sweet ... (Judith frowns). Hetty gave it her."

Judith: "Did you tell her?" (I think she meant Sandy).

Nola: "Yes I told her. I said Hetty you naughty girl you shouldn't have given Blanche a sweet ..." (Lounge)

Here Nola appears to misinterpret Judith's point giving an account of her chastisement of one of the confused residents instead.

Therefore, lovelies were useful to the staff in saving them time. They were praised for their information and appeared to be the only resident group who were seen as trustworthy as adults within the home. The 'lovely' status could be construed as both an ideal type of good resident and as a reward for compliant behaviour. In this way it functioned as a form of social control.

Other Social Groups

The ladies were four women residents grouped together as all having a high class status. 'The ladies' stood out from the other residents, they had lived life in considerable luxury

and in appearance seemed from affluent backgrounds. They never used the lounge and came down only for the evening meal, for which they sat on their own table. Similar to the disliked, they gained the quickest and best service. Unlike the disliked, they were perceived as having earned this by virtue of their social backgrounds, they were "real ladies", who deserved respect.

Although there were highly developed typifications in Hazelford Lodge, there were four women residents whose typification was very weak and whose lives made little impact on life in the home. Workers knew their personal information but these people were not loved, hated nor problematised in the same way that the others were. These residents had very strong family and friendship networks and were rarely at the home. Their lack of contact with staff meant they could not be typified.

Physical Typifications:

The Sick

The 'sick' group were made up of two groups; those residents who were temporarily labelled sick by virtue of their physical state and those who were perceived as generally 'sickly'. This latter category had commonly been admitted under conditions in which they were already labelled as sick, usually from hospital, nursing home or by recommendation by their General Practitioner. The sick often had chronic illnesses, but unlike other residents, also had mystery ills, which could not be diagnosed by medics. This uncertainty seemed to lead to over cautious care. Despite illness, the sickly were unlikely to be categorised as nursing home or hospital material unless they became confused.

Example

Glenda appeared to be the resident considered the most sickly in the home. She exhibited a mixture of medically diagnosed illnesses and mystery symptoms. Glenda was very polite to staff, constantly apologised about causing assistants trouble and joked about her ills. The care assistants liked this "lovely old granny." (Eileen)

Disliked people who became sick were treated as any sick resident. Sickness and dying, seemed to neutralise staff dislike and sick residents were absolved from responsibility for abusive behaviour towards staff. 'Sick' especially sickly appeared a permanent typification but it did have some privileges. The workers liked dealing with the sick, as

long as they did not fall sick in droves. Sickness led to getting individualised meals and treat food such as jelly and ice-cream, biscuits and cakes. Assistants would serve the sick food in bed at all hours, and gave extra comfort. Sick people were liked by staff because they accepted care. They allowed themselves to be cuddled and comforted, fed childlike foods, be patted on the head, referred to as 'girls' and 'boys' and ordered, they were the perfect recipients of emotional labour. Work could also easily be ordered around them as they were passive in their environment. Sickness was largely attained through past health record and the current exhibition of passivity and acceptance of worker power.

Sickness, did not generally lead to movement into nursing care. The assistants constructed nursing homes as storage spaces for the uncontrollable "doo la lee" (Joan) and thus it was only the confused who were perceived as on the border of this form of care.

The Confused

Four residents were introduced to me as 'confused' they were often lumped together in the planning of chores and events. At times these residents showed signs of being uncontrollable within the forms of control viewed as acceptable within the care assistants' discourse. As a result two were moved onto nursing care shortly after the block observation period.

Hetty, Blanche, Ida and Milly appeared inseparable in the home's routine, they were quite demanding to care for as they were all incontinent and had bouts of bewilderment. In the mornings they were often the first dressed and down for breakfast. During the day Hetty, Blanche and Milly sat together in the communal lounge by the large bay window overlooking the garden. Ida sat alone in a corner waving at those who walked by. Once seated these residents generally did not, and were not expected to move, except for meals or the toilet. The 'lovely' residents took an interest in caring for them as if they were children. At mealtimes Hetty, Blanche, Ida and Milly sat on a table near to the service hatch. This allowed staff to watch them but not be seen.

Despite their difficult properties the confused residents were generally considered as liked and got temporally more interaction and interest than some other types of resident. Workers expressed a preference for caring for confused people, arguing that they could do what they wanted with them more easily.

Joan: "With the senile ones, you can treat them a bit more institutionalised."

Eileen: "You can do more with them (the confused). You can get them up, you get to know them, but with others you rarely see them, they're able."

Confused residents allowed a form of access and power over their lives that other residents would not, they were 'good' residents because they could be coerced, bribed, kissed or cuddled into submission.

The interaction between 'confused' residents and workers was qualitatively and quantitatively different to that used with other residents. Confused residents tended to be spoken to by the assistants more and for longer periods. However, conversations were usually repetitive, based around the care chores and were jocular and over positive in tone. They were also characterised by use of semi-childlike, derogatory or colloquial slang language. This usually materialised during personal care of the body, which was a more prominent feature of the confused residents' care than for other residents.² It was also typical for the assistants to provide a running commentary on the chores whilst dealing with the body.

Example

Julie was getting Ida ready for bed;

Julie: "Lets have a look at your bum chum."

Ida: "He's alright" Julie gets the flannel.

Julie: "but you've got skiddies in your pants, open your legs (laughs, begins to wash her), you love it, (Smacks Ida's bottom lightly), now we flour your fairy." (Applies talcum powder then rummages in a drawer)

Ida: "What are you doing?"

Julie: "Looking for bed socks your tootsies are cold. Come on then, get on the crapper."(Bedroom)

Therefore it is possible that the form of interaction could be associated and used with the personal chore rather than the type of resident but from my data is the relationship is unclear.

Use of this type of language was entirely different from that used with all other residents and it seemed to reflect the down-to-earth tasks that the confused resident represented for the assistants. Confused residents were unlikely to report this or complain.

Confused residents appeared to be considered as unoffendable and bodily references were made regularly. For example, it was common in the lounge to hear assistants ask the confused residents on the way back from the toilet, "Did you wee on the floor?" It was also common to observe the practices of assistants feeling under the crotches of confused residents from behind, to see if they were wet. Yet, non-confused residents with incontinence were treated with discretion. It was clear that this overt accessibility to the body allowed a control over the confused that was far more extensive than other resident groups. This appeared to be rooted in the assistants' understanding of confusion as childlike.

Confusion As Childlike

The theme of confusion as a regressed child-like state, rather than as adults with an illness, was strong.

Sandy: "They're just like kids, you just have to talk slower and explain things to help them keep up."

Workers also referred to working with the confused as more tiring than caring for children, and it was thought that out of all the residents they were the least able to make choices for themselves. This led to their forced participation in activities.

Enforcing certain behaviour was not only perceived by workers as a general work strategy with the confused residents but was treated as part of a war of wills. One is reminded of the notion of the 'breaking of will' mentioned by Goffman (1961,27) as part of the process of the creation of the inmate by staff within institutions. The assistants' discourse saw physical force as an unacceptable method of obtaining compliance from residents, and thus the 'breaking of will' in Hazelford involved methods such as, coercion, encouragement, kind words or blackmail. For example, on one occasion a confused resident was observed being told by an assistant to drink her tea down or she would not

leave the dining room, she duly drank it down and vomited. The assistants then concluded she was sick and put her to bed.

It seemed important to the assistants that the confused should participate in group activities, and this appeared to be seen as part of the way to proving to outsiders that care was going on.

Kath: "Ida's just come back from a walk with me she enjoyed it."

Eileen: "Did she? Did she want to go?"

Kath: "No, but once she was out she loved it."

Eil (turning to me): "That's what it's like, they don't want to go but once they're out they like it."

Julie: "Yes, like trips, once they're in the bus they have a good time." (Lounge)

In this context pressuring and bullying became part of care because the confused were viewed as unable to make choices as normal adults.

Nursing Home Material; Someone Else's Problem

Part of the role of typification at Hazelford was the creation of boundaries of legitimate work and that which constituted someone else's problem. Certain types of older people were not their concern, these people were labelled "nursing home material". The main criteria for this typification was an unresponsiveness to control through emotional labour. These cases were usually moved over to Bracken Court nursing home.

Nursing home material was verbally described as having "totally lost it", "gone", and was "dappy", "doo la lee" and had "lost their marbles"; there was a pervasive theme of loss. Nursing home material was only very rarely defined via physical ill health alone; it was more concerned with the residents' mental state.

Although workers commented that working with the confused residents was the type of 'real' work they'd prefer, it was usually these residents who eventually could not be accommodated and disciplined within Hazelford Lodge. Nursing home material often developed a different pattern of confused behaviours which were dangerous or socially offensive. 'Wanderers' who left the safety of the garden area, residents who would

undress themselves, defecate in public or were highly aggressive, were no longer within the boundaries of a comical construction.

Example 1

Hetty began to wander a lot at night disturbing other residents. The wandering occurred for a few nights before staff commented Hetty was becoming N.H.M. However, Hetty quietened down and the label passed. Six months later her behaviour became worse again and this time could not be disciplined with soft words. Assistants confided that they were, "At the end of our tethers." (Sandy) Eventually Hetty moved over to Bracken Court.

Example 2

Blanche became very confused during a period of illness and began to wander out of bed and down the corridor at night. She represented a level of supervision that could not be given within the time and work constraints of the routine. However, she regained her previous state and went back to being just confused. Eventually though, evidence was gathered to show she was getting worse again and when her incontinence and constant shouting of "help" began to disturb order in the home, she was moved.

Sue: "It was getting past a joke ... When we sat her in the lounge she shouted help all the time annoying the other residents and even when we were with her she shouted, but there not enough of us to be with her all the time ... at night she wandered down the corridor and sat by the lift shouting for help."

GLT: "Is she better over the nursing home?"

Sue: "No she sits in a chair and shouts help." (Smiles jubilantly.)

Verbal accounts of moves, as illustrated by Blanche's case, suggested that a downhill movement with increased unmanageable symptoms led to the label of "nursing home material" which was officially taken to represent the need for nursing type input. However, those who were moved were unresponsive to the care assistants attempts to discipline them. In Hetty's case her wandering could usually be stopped with a 'kiss and a cuddle' but later she became unresponsive to this and agitated. One night I witnessed a care assistant, who had been up for two hours dealing with Hetty, trying to cope.

Teresa: "Get back to bed, for Christ's sake how many times?" Hetty responded by turning towards her room, Teresa turned to me, she seemed embarrassed at her behaviour. "I don't shout usually but she's going to have to go."

Hetty was beyond the methods available within the care assistants' discourse to discipline residents.

Care assistant accounts of why residents were moved on, did not highlight the nature of the power balance that existed between resident and worker, and which through severe confusion was lost. Although the disliked were also unresponsive, moving them on could

not be justified by their mental state. Night workers gave an interesting insight into the process of moving people on and the collection of 'evidence' in the case of one female ex-resident.

Kath: "There was this woman here once, and me and Joan didn't like her and we used to write that she was up wandering into peoples' rooms because she pissed us off ... she's in the nursing home now ... you have to write something so they know you're working."(Lounge)

The night workers description of how easy it was to construct the disliked woman as "nursing home material" relied upon using credible examples of behaviours that were not amenable to discipline within the care discourse. Through this the behaviour of the resident became sited within the 'other' of the nursing home, and although much of the evidence was fabricated or exaggerated, the story had a discursive credibility. These were behaviours that the discourse constructed as possible within elderly people and as indicative of the transition of a resident towards being someone else's problem.

Conclusions

The typification of residents at Hazelford Lodge was a way of ordering residents to make their processing through care easier. Typification allowed a pre-empting of individuals behaviours, and, whilst the format of typifications could be loosely broken into the social and the physical, they were both constructed around the level of difficulty that the resident represented as a work chore. They also appear to embody the level of acceptance the residents had for worker control through emotional labour, access and infantilisation.

The forms of the typifications also depicted the way the assistants' discourse constructed ageing and degeneration as a complex, stepped, downhill process but one over which, at least at the external boundaries, they had some control.

CHAPTER SIX: DISCIPLINING OTHERS

Introduction

Ordering the inside of Hazelford Lodge was not just an issue of controlling the residents. New workers and others who crossed the boundaries of the home had to be ordered. For the care assistants the rigid hierarchy and regimented work structures often identified with nursing, did not exist. Notions of the care assistants working for each other and being seen as part of a team were central to maintaining order within the work group. Ordering others was also problematic as the assistants had to appear caring and yet maintain ultimate control over the home. These issues were central to the construction of work.

Section 1: Ordering Each Other

The ordering of care assistants at Hazelford Lodge was largely informal. For example, despite Matron's power to hire or fire she never appeared to need to evoke her status to get the other assistants to work. The willingness to of assistants to work appeared to be rewarded by the esteem of other assistants and their acceptance into the work group by their peers. Labels such as 'lazy cow' or 'slacker' were available to apply to those workers who did not work hard enough and bad workers were treated with indifference by the others. However, good workers, rather like Oakley's (1974,103) good housewives, were never openly complemented on their work.

The good worker had ability, competence, good humour and speed in domestic tasks. Speed was perhaps the most important factor, it was the ability to cut corners and yet do it right that was most respected and often expected. But also of importance was showing oneself to be willing. Assistants would often fight for the nastier chores running when the buzzer or phone went, insisting on taking the upstairs trays in the morning, doing more chores than were necessary to 'save' others.

Example

Marie returned to Hazelford against doctors orders having had major surgery. She was quick to prove she was fit, insisting on undertaking all the chores and lifting residents, despite other workers trying to stop her.

These altruistic acts were compulsory but rather than being based upon who was the hardest worker and the toughest, they were grounded in a notion that the care assistants were a team and that to bother others was to let them down. Hockey's (1990,112) observation of care women 'competing' to do chores to prove themselves "nice natured" was mirrored at Hazelford. The reward for the good worker was acceptance by her peers.

Bad Care Workers

Those workers considered bad workers were mainly weekend staff. Weekenders did not mix with general staff, in this way they were almost a distinct work group. They did not really belong to the general work group as few other assistants worked with or knew them. Jealousy also seemed to play a role in the other assistants' dislike, as weekends were seen as easy shifts by other assistants. There were less domestic chores at weekends and some argued that the weekenders had more than their fair share of entertainment chores.

Eileen: "They don't have any baths to do and there's only taking someone like Blanche to the loo occasionally."

More generally there were two features that were taken to be indicative of bad workers; being "dozy" and being "lazy". Both of these led to slowness at work chores.

Example 1 Jenny, (part-time days)

The general view of Jenny was that,

"She hasn't an ounce of common sense" (Teresa).

This led her to undertake chores in a slow and inefficient manner, tending to work on one chore at a time and often repeating them without realising. Jenny was prone to discussion about undertaking the chores,

Eileen: "I say Jenny just do it, there's no need for all this"

Jennys' activities did not involve time saving.

Example 2, Lena, (Part-time weekend evenings and some weekdays)

Lena was severely disliked and this seemed to be related to her perceived laziness:

"That Lena's so lazy, no one likes working with her." (Kath).

Whilst Jenny was put up with, Lena was perceived as needing to be constantly reminded to get on with her work.

Bad workers made ordering the home difficult as they did not react to the ordering influence of the team.

The Categorisation of New Workers

The categorisation of new workers occurred very quickly and the labels tended to stick, despite workers' attempts to change behaviour or re-categorise themselves. During the fieldwork three new workers began at the home. The cases of Betty and Hilary illustrated the importance of early typification to being seen as a good worker later on.

Example One

When Betty began work mutiny threatened. She refused to take orders and when put right she went into a "sulk" (Eileen). She was seen as a,

Kath: "Bit of a madam ... coming in as if she owned the place."

Informal staff discussion deemed it was necessary that Karen should speak to her. After this Betty appeared to make active attempts to be accepted by showing interest in the other staff and working hard but staff never accepted her totally.

Maggie: "She'll change her ways for a while and then it'll be back to the other."

Six months after the observation Karen confided to me that Betty, although accepted as a worker, was still 'difficult' to deal with and although she had proved herself as a worker, she had no sense of humour and was a "show off".

Example Two

Hilary, a new night worker, was quiet, asked for and listened to the other workers advice. She asked questions about residents, was deferential to other workers, cheerful and got on with the chores. A few weeks later Hilary had gained the label of acceptance in being a good worker, and "a bit of a laugh" (Maggie).

The staff discourse was characterised by a strong sense of boundaries and loyalties between the assistants. Good workers had to discipline themselves into being part of the group, which entailed being self-sacrificing and hard-working. The right attitude was needed above qualifications, and although staff felt that any woman could do their job, not everyone had the right disposition for team membership.

Section Two: Ordering Others

Doctors, relatives and other visitors to the home, were largely seen as an intrusion into the routine. However, they were accommodated if they behaved as the assistants felt visitors should: respected the residents, did not criticise care or disrupt the routine and did not stay too long. At times, the care assistants appeared to actively manage these

groups, using them to support their own plans for residents. The root of this ability to manage these other groups stemmed from the assistants' ability to convince them that they were suitably qualified to act as advocates of the residents. Generally visitors and others accepted this, but maintaining this order was a daily work.

Relatives - Ordering Them

Relatives, as with other aliens, were expected to accommodate themselves to the home and the unwritten rules of conduct. Certain behaviours were constructed as upsetting for residents and disruptive to the usual order of the home. These included: noise making, creation of over-excitement, sadness or anger, calling at 'incorrect' times (meal times, late evenings, early mornings etc.) and not ringing the doorbell when entering. However, these behaviours often appeared to disrupt the care assistants rather than the residents.

Example 1

Lily's daughter Marjory visited her mother every day and was considered a good relative. However, a problem arose over the staff Christmas show when, encouraged by the assistants, Lily organised a long old time music act which overran. In the workers' words Lily was "taking over" (Sandy), she was breaking the unwritten rule that the workers were in charge. Although this did not appear to have worried the residents, Marjory had taken the 'belonging' status too far and her behaviour was labelled as inappropriate.

Inappropriate visiting behaviour involved visitors not observing the visiting hours seen by the assistants as 'normal', doing things that assistants' considered strange or suspect, like wandering around, and not showing due respect toward staff. It was also deemed necessary that the relative or visitor should accept the assistants assessment of those they visited. In this way the assistants promoted themselves as the experts in terms of their charges.

Some visitors, by virtue of the length of time they had visited and their compliance to the informal visiting rules, became part of an 'insider' group to the care workers. They were people around whom staff behaved as if they were not there. Around these visitors the mention of incontinence and the infantising interaction that usually was used with residents could continue, often with the relatives joining in.

Relatives - Caring For Them

The role of the assistant seemed to extend beyond the care and ordering of residents, to the care of relatives in times of social and emotional disruption. I observed one resident dying at the home during the block observation. Matron organised the funeral and legal affairs, as one would expect, but I also saw night workers feed and comfort the dying woman's son and others generally support and counsel him and his family when they arrived. Assistants were thus involved in the organisation of emotions as well as the practical details and there seemed a similarity between this work and the role of funeral directors. Hockey (1993,94) in a study of funeral directors noted the way they organised the passage of grief for relatives and contained upset. Similarly the assistants were involved in aiding the relatives during times of grief, but also in containing the emotion, lest it upset others in the home.

Support was also given to relatives when the residents made the transition between resident and nursing home patient. Some visitors continued to call after their relatives died or were moved to Bracken Court.

Maggie: "One resident she went over the nursing home, but her daughter used to come in and have a cup of coffee with us because she said nobody would talk to her and 'I've come in to have a chat' after visiting her mother."

It appeared that very often after a movement from Hazelford, especially to Bracken Court, relatives maintained a relationship with the Hazelford staff and other residents and visited regularly. Assistants appeared to be involved in supporting relatives through the negotiation of the boundaries of death, illness or movement to another place and normalised these passages through support.

Doctors

Doctors were constructed in two modes, the good and the bad. The assistants' views on doctors were often expressed in anecdotal format. These stories had common themes, the bad incompetent doctor was encapsulated in 'we told him/her but he/she wouldn't listen' stories. According to the assistants it was common for new and young doctors to tend to dismiss the their knowledge. The stories stressed the inadequacy of medical knowledge against experience, and the necessity of maintaining control when dealing

with such doctors. Thus they reasserted the importance of the care worker. A badly controlled doctor would lead to resident being very ill or dying.

Example

Julie was tending a resident who had a distended stomach, she began to give an account of another resident who had similar symptoms but died. The doctor's incompetence was contrasted with the knowledge of the workers.

"It's the same as this lady we had in, she had a distended stomach, wind and pain, it got worse and they (the hospital) took her in the end but the doctor wouldn't send her in for tests in the beginning. It turned out that she had ... (she runs through a list of medical conditions) ... anyway, something or other and she died and that was just like this (lowers her voice) but Dr. S won't send her in." (Corridor)

The underlying theme of such stories appeared to be the damage to the resident when the experiential knowledge and advice of the care assistants was ignored.

Bad doctors were those who the assistants thought downgraded their work, disliking older people, and who were not thought to enjoy their visits to Hazelford Lodge. Those who ticked workers off for calling them out for problems that turned out to be trivial were particularly disliked. These doctors did not respect the uncertainty with which assistants viewed the health states of their charges. All new doctors were viewed as bad at first, as were temporary doctors.

The best doctors for residents were their own doctors, especially if they were experienced. Good doctors were also constructed as highly interventionist, likely to order tests, change prescribed drugs and/or dosages, and thus seemed to act upon the care assistants' concerns.

Example

Blanche, had been ill for sometime, a doctor had come out, doctor G, but he was not Blanche's "proper" doctor. The result of this, according to the assistants' accounts, was that he did not properly ascertain Blanche's physical state as he did not know her. No medical or pharmacological action had been taken and he'd advised bed rest for a "virus". Doctor O, Blanche's "proper" doctor who had treated her for some years visited some days after, Karen commented on the difference between the two doctors.

Karen: "She's got bronchitis and conjunctivitis and the doctor (Dr.G) should have known, but frankly doctor G doesn't bother about the old, but Dr. O has given her antibiotics." (Kitchen)

Taking some form of action was understood by the auxiliaries as a sign of a positive, caring attitude to the residents. Also, "proper doctors" were the only ones who, through

virtue of their long-term experience of the resident, could possibly provide a 'true' diagnosis and treatment.

Good doctors also listened to care assistants and respected their opinions. This made them particularly useful when the assistants felt a patient needed to be moved onto another form of care and the resident, or their relatives, felt this was not necessary. With the good doctor 'on side' residents could often be talked into moving, and the argument had a medical legitimacy. Thus, the doctors that the assistants liked were malleable to their aims and also gave encouragement to the care workers.

Example

Dr. S often congratulated staff on their care. He was taken to be a "good man" who cared for the residents, he had been practicing around the local area for years and was close to Matron. In sharp contrast, was the construction of Dr V, who had only practised for six months in the area and was described (negatively) as "foreign" (French). He was viewed as inexperienced and when, for example, he failed to give drugs to a resident that workers deemed as ill and that they had 'diagnosed' as in need of painkillers, his typification as bad was sealed.

Other medical or nursing personnel were treated and assessed in a similar way to doctors. Those who challenged the workers' assessments were typified as incompetent and potentially dangerous to the health of residents.

Control Over Other Places

Residents were most likely to come into contact with other places which offered alternative forms of care to the residential home, such as hospitals, relatives' homes and nursing homes. Thus they were a threat for the assistants and were places over which they had little control. Assistants depicted other forms of care as sub-standard, and attempts to move residents were blocked on this basis. For example, the assistants argued that nursing homes were busy places where residents got lost behind chores. Where possible, the assistants would prevent transfers to nursing homes.

Eileen: "They don't speak to them like we do, they don't have time."

Also the assistants maintained that the number of mentally distressed patients in nursing homes made such an environment inappropriate for many physically sick residents,

Jacky: "They're all dappy over there and it's not fair to put someone there if they've got all their marbles."

However, when a resident was very confused the assistants advocated a move to other forms of care. Working with the very confused was seen as beyond their remit.

Hospitals were depicted as dangerous places which were not just busy and inhabited by the confused, but also were also uncaring and negligent.

Maggie: "They come back (from hospital) worse."

Karen: "Bedsore and malnourished."

Maggie: "Catheterised, doo la lee ... remember Mona? She came back Catheterised."

Eileen: "And she wasn't even incontinent!" (Kitchen)

Staff argued that residents who came back often had to be nursed out of the patient state.

Thus, hospitals were places of last resort.

Conclusions

For the care assistants at Hazelford Lodge residential home, control and care issues extended beyond the care and ordering of the residents, to each other and others who entered the building. However, with all these groups the notion that the assistants were 'caring' was the root of their status and control. It was also the justification for their actions. For example, it was the idea that the assistants cared for the residents which gave them a special relationship with relatives and authority with 'good' doctors. Those who refuted or denied this power were ignored, avoided or put up with, whereas relationships with those who were accepting of the power of the assistants were cultivated.

Although care was the organising feature of the care assistants' work, it operated as a form of control. Care involved nurturing and providing, but also containing, sorting, processing and using emotional labour to manage individuals. In this way the work of the care assistants at Hazelford Lodge appeared both an elaboration of certain aspects of women's roles in the domestic home, and an integration of others more akin to general work. Thus, their paid care work used care as much as provided it. The residents were managed on the basis of their acceptance and reaction to the use of the caring role.

CHAPTER SEVEN: THE AUXILIARIES' WORK AT BRACKEN COURT

Section One: The Nursing Auxiliaries Job

Although the auxiliaries' official job description was the same as that used for the care assistants, the way care was enacted by these workers was quite different to that used over 'the other side'. Work was involved with maintaining a firm order over patients' bodies and behaviours, and normalising them into the patient expected by the home. The auxiliaries worked in two main areas, the lounge and the bedroom, spending the most time in the latter. The home demanded an especially strict ordering of patient behaviours in the lounge area, and the bedroom largely functioning as a preparation space for the patient's body and mind.

In the bedroom areas, which were hidden from the view of the trained staff, the auxiliaries' construction of care appeared to be entwined with strategies of control. Within this the patient became the object of conveyor belt caring and although the physical standard of care was often very high, psychological care or even a view of the patient as an individual was usually non-existent. Working largely in spatial separation to the trained staff, it appeared that the auxiliaries had developed their own stratagems for control in different areas.

The Lounge Job

In comparison to the work of the care assistants at Hazelford Lodge, the lounge work of the auxiliaries was only a minor part of their job and involved brief chores such as, feeding patients, placing them in a chairs or handing out drinks. The lounge represented the public front of Bracken Court and the space was worked in mainly by trained staff. The auxiliaries exhibited non-confrontational behaviour to patients in this space and attempted to control and contain distress in these public areas.

For example, mistruths about if/when patients were going home were used routinely by auxiliaries to calm down distressed patients. Trained staff used mistruths but only to answer the patients' questions. However, auxiliaries used mistruths to manage, induce

and control behaviour. For example, they were used to get patients to eat and it was common to hear comments like,

"If you don't eat it up I'll lose my job and be in trouble."

"Last mouthful and then I'll go away."

Sometimes patients were threatened with their own relatives,

"What shall I tell your husband?"

But mistruths acted to calm patients down in the short term and could be used in front of relatives, who appeared to view them as a form of being kind. When patients got upset there was a re-focusing onto positive concerns, often ignoring the patients' fears.

The hiding of distress was part of the auxiliaries' job to conceal the very nature of the home. Bracken Court advertised itself as a place for elderly people to live, however the reality of life in a home could suggest that movement into a home symbolises a detachment from the community and the beginning of a career towards death. (Gustafsson, 1972, Mulkay and Ernst, 1991, 182). Auxiliaries tended to emphasise routine in the interactions they had with patients in the lounge,

Example

Pippa: "I don't want to be here I want to go home."

Jill: "It's alright, there's a nice cup of tea in a moment."

The strong focus on routine served to emphasise life so death occurred, a gap was not apparent. The lounge was an exhibition of home life with the abject aspects of ageing hidden, and it was the auxiliaries' job to create and maintain this illusion.

However, within the lounge private spaces could also be created by use of clusters of the high backed chairs. After relatives and the general public had left and when trained staff were temporarily not in the room, the lounge was reconstructed as private space. The characteristics of auxiliary behaviour in the lounge during these periods was more confrontational.

Example

Whilst a relative was sat with the demented cluster, Maddie (aux.) was kind, and even laughed when one patient spat food in her face. But when the relative left to speak to Matron and another patient refused to eat, Maddie threatened; "I'll push your face in it in a minute" and referred to the home as a "mental hospital".

It is through such private acts that the atmosphere of the more private areas were evoked in the public spaces via, as Goffman (1959,132) argues, the adoption of behaviour usually seen in another 'region'. Challenging behaviour was more usual in the bedrooms.

Any outbreak of disorder in the lounge reflected back onto the home and the auxiliaries' standard of work. Control and containment were essential in maintaining order here, this was done via a mixture of joke, threat and lie.

Section Two: The Bedroom Job

The bedrooms were the main sites of work for the auxiliaries and most of the patients' time in the home was spent there. The tasks of this space included: getting the patients up, aiding them to eat breakfast, dressing, washing, undressing them and putting them in bed. They were all tasks which left the patient passive and included a great deal of ordering of the body.

Certain states only existed in the bedrooms: violent outbursts, noisy confusional outbursts, shouting, spitting and other anti-social behaviours, continual rapping on tables, sticks on floors, persistent crying and sobbing and acute sickness. These type of behaviours, if displayed in the lounge, were immediately physically confined to the bedrooms by the auxiliaries. Those who were left 'displayed' in the lounge were those who fitted the home's construction of the ordered patient, the physically, mentally ordered older person, dressed tidily, unsmelly and clean.

Ordering the Bedroom Space

The provision of shared rooms in the home, allowed a ward scenario to exist beside the private single rooms. In these spaces there was an opportunity for a more social type of interaction and also the chance for auxiliaries to encourage interaction between patients. However, interaction was not encouraged by the auxiliaries and it seemed that they often sectioned the rooms into individual areas which they created through manipulating the surrounding props.

The first bedrooms to be "sat up" were the 'four bedder' and the 'two bedder' along the top corridor. The patients in these rooms were considered to embody heavy chores that needed the labour of more than one worker. The 'four bedder' was always done first. This was a large room with four patients, three of them large and immobile, and two with confusion. The room was spatially organised with the four beds in each corner, and each bed had the potential to be sectioned off by a curtain for extra privacy. Interestingly the curtain was not often used for this and when it was it often still left a partial view of the patient from the corridor.

Example

"The three auxiliaries joked whilst they washed Pippa (Patient). Then I heard a moan from behind a curtain, another woman was in the room hidden by a curtain which was pulled around her bed. Effectively she did not exist in the interaction."

The patient appeared to have been placed out of sight and out of mind.

Space and structures were used in an isolating way, which made the inclusion of the hidden patient less necessary. Creating spaces allowed the auxiliaries to make distinctions between chores. Once one patient had been 'done', the curtain could be pulled back to allow the next to be attended to, a kind of spatial chore waiting system.

The bedroom job was heavy work, with workers expected to get the patients from a disorderly physical and mental state into one in which the patient became of a 'lounge standard'. If order should breakdown in the lounge it was the auxiliary who was sent to collect and reorder the individual in the bedroom space. This "technical work" (Goffman,1959,126), and the auxiliaries who undertook it, were largely invisible to visitors and others.

Creating the Disciplined Patient, A Private Task

The creation of the lounge standard patient was dependent upon the bedroom work of the auxiliaries and the effective normalisation of the patients' bodies and minds. Most of the auxiliary behaviours exhibited in the bedroom acted to effect a state of compliance and create the lounge standard patient. These acts could be analytically divided into two, acts of mistreatment, and punishing behaviours, both of which were viewed as acceptable

within the discourse of care. Care appeared to often become direct control and regulation in these settings. Mistreatment was part of the daily grind of getting through the work, of organising people in conveyor belt fashion to time and chore constraints. Punishment, apart from being a more deliberate and personal form of cruelty, involved getting back at the job and taking it out on the objects of care.

The auxiliaries did have boundaries of behaviour towards patients, for example, to hit them was seen as totally unacceptable. However, within the discourse there was no notion of mental cruelty, and telling people off, ignoring them and 'teaching them a lesson' in ways other than physical violence, were seen as acceptable and as part of work. It was also the auxiliaries' role to deal with the patient who had behaved badly in the lounge, to make it clear that certain behaviours were not acceptable. In the bedroom the auxiliaries were actively engaged in both the dirty work of caring for bodies and the dirty work of creating general discipline.

Mistreatment and Depersonalisation

Mistreatment, unlike the overt punishment of patient misdemeanours, did not appear a conscious way of ordering the patients' behaviour. However, the processing of patients as chores, ignoring them as people and the systematic disregard for their psychological welfare had largely the same effect. Many patients exhibited a pattern of withdrawal from their surrounding environment for a large part of the day. Although chronic illness could explain some of this behaviour, similarities could be drawn to the category of "situational withdrawal" used by Goffman (1961,61) to describe some inmates' reactions to incarceration. Many of the patients at Bracken Court had withdrawn to the extent of ignoring those around, and even their own bodily needs.

Truth

Communication in the bedroom areas was characterised by non-communication or alternatively 'hard' communication, that which was distressing, aggressive or demeaning to patients and seemed aimed to produce fear or tears. Patients asked highly threatening questions, similar to those asked in the lounge: why they were there, when they could

leave, some would just demand to be taken home. However, bedroom answers were often the direct opposite to those given in the lounge.

The 'truth' was often presented in such a ruthless way it appeared to deny the legitimacy of patients' distress.

Example

Two auxiliaries, Sally and Ann, were in Celia's room getting her ready for bed. Celia was a confused patient who often got upset and was considered to suffer from 'sulks'.

C: "I'm going home."

Ann: ... "Now listen to me, this is your home, you can't look after yourself."

C: "But my son."

Ann (butts in): "No, now listen, your son and daughter in law go out to work and there's no one to look after you, that's why you've come in here and you're going to have to accept that."

C: "I'm going home." Ann repeats the above argument virtually word for word. Outside Sally spoke to me.

Sally: "It sounds bad to people who don't know, but you've got to tell them the truth, you can't lie to them."

This kind of 'truth telling' by auxiliaries was the opposite to the behaviour used in the lounge. The fear of the disordered behaviour that telling the truth might produce was not important in this 'naturally' disordered private space.

Ignoring Patients' Words

Part of the overall order of the home involved a passive mistreatment of patients everyday interaction rituals. Interaction in the bedrooms was one-sided and rhetorical. Partially this was due to the lack of response by patients who were too tired or could not respond themselves. This was the case with a few highly demented or very seriously affected stroke victims. However, the auxiliaries tended not to speak to patients or encourage talk from those who could speak.

Many patients' speech could not be understood, even by the auxiliaries who had worked with them for some time. It appeared in these cases, that auxiliaries often answered noises in a ritual fashion. But talk often appeared ritual in nature anyway, as it was usually chore orientated and auxiliaries rarely took notice of the patients' replies.

Example

Maddie and Janet were dressing Kate (patient) in her room. Kate was lucid and articulate but had poor sight.

Maddie: "What do you want to wear?"
Kate: "My red top and grey skirt."
(Maddie fiddles in a drawer) "Where are they?" (To Janet)
Janet: "They must be in the wash."
They begin to dress her in something else.
Kate: "Is this my red top?"
Maddie: "No, it's a pink one."

In this case a question was asked but the auxiliaries did not think it important to tell the patient what was going on around her. Through ignoring the patients' words the auxiliaries made them non-important actors in the setting, and often appeared to treat the patients as spaces and objects, rather than as people.

The auxiliaries commonly ignored the presence of patients, preferring to talk about them in the third person and sometimes being insensitive.

Example 1

Maddie was up working in the four bedroom with Delia (patient). At one point she began to tell me Delia's medical history whilst Delia lay below us in the bed.
"A few months ago she was very poorly, actually she nearly snuffed her candle." (Delia looks up afraid, Maddie does not appear to have noticed this and continues talking)

Example 2

Sally (aux.) went into John's room to settle him for the night. She went across to the window and picked up a photo of him. John was in the bed, fully awake,
Sally (to me): "This is him before the stroke, bloody shame isn't it?"

It was as if the auxiliaries assumed that all the patients could not see, hear or understand these comments. This did correspond with the general view held by the auxiliaries that none of the patients were fully 'with it'.

But there was also some difference between the treatment of patients who were considered relatively lucid, and those who were seen as having a mental health problem. The latter were more likely at any time to have their words ignored, and to be ignored in their own rooms. However, at night treating patients as objects was the sole form of interaction observed. This was illustrated by the type of dehumanising ritual observed on rounds, during which patients' rooms were entered, their urine bags emptied and beds checked for soiling. This was a noisy, depersonalising process in which patients were rarely acknowledged and the auxiliaries often chatted or joked whilst undertaking chores

upon sleeping patients. Patients who awoke during these tasks, often lay silent and motionless whilst they were rolled over, moved and worked upon.

Ignoring Private Space

Private space for the patients did not appear to exist in the home. Their rooms were colonised by auxiliary staff as work spaces and when they were alone they had no privacy as knocking on doors was not seen as important. Issues of privacy and space were never broached in report either and this lack of normal interaction rituals was not seen as problematic either by the auxiliaries or trained staff.

Abrupt entrances were often followed by invasive procedures to see if the occupant of the room was soiled, such as rolling people over to look at their bottoms and then giving some brief explanation for the procedure. When the physical status of the patient was ascertained the patient could be cleaned up, dressed, got up etc. Once a work chore was done there was a tendency for auxiliaries to leave, the shutting of the door seemed to suffice as the end of the interaction.

Example 1

The two auxiliaries dressed George with a running commentary to him about what they were doing. Once finished they lifted him into his chair, and as they went to leave, Lucy turned to the other auxiliary and said loudly, "Right that's done." The lack of normal entry and exit rituals was not particular to any shift.

Having A Joke With Patients

Some acts of mistreatment appeared to stem from a lack of sensitivity to patients' needs. Making jokes at the expense of the patient, and especially mimicking their behaviours, was seen as "having some fun with the patients" (Velma) and the auxiliaries argued it involved patients in some way with the work. But laughing at the patient appeared to be an in-house one-sided interaction for the benefit of staff only, as most of the patients could not hear or see these jokes and others appeared to choose to ignore them. Jokes appeared to help the auxiliaries get through the work, broke up the stress and gave them some sense of control. However for residents, such jokes were probably dispiriting.

Example 1

It was morning, in the four bedded room Minnie, a patient with dementia was lying on the bed whilst four workers got another patient up. She began to grunt, a noise characteristic for her in the morning.

Judy: "What's up with Minnie?"

Carol: "Sounds like she's having good sex to me." (laughter)

Example 2

Dena and Judy (night staff) went into Mabel's bedroom. Mabel was lucid but had very poor eyesight and hearing.

Dena: (to me as we go in) "We always have some fun with Mabel."

Mabel: "Who is it?"

Dena: "Its only us Mabe, Floss and Flo, the night staff." (giggles)

Mabel: "Oh hello my dears, how are you, I haven't seen you for some time have I?"

Judy: "No we've been in hospital."

Mabel: "What's that for then?"

Dena: "Blocked tubes Mabe, you know women's problems." (Laughter)

Mabel: "I had that once ..." Mabel begins to tell a story about hospital treatment when she was younger, the workers sit and giggle at her story and in the middle butt in,

Dena: "Well we've got to go again now, we're very busy. (She comments as we go out the door) What was she on about?"

Example 3

Judy and Zara were in Penny's bedroom. Penny who was "confused" (Julie), often repeated her name which was the source of great amusement to the auxiliaries;

Julie: "Watch this" (to me), leans on bed, "I'm Penny Jackson." Penny looks at her bewildered but doesn't answer.

Julie: "She usually says 'No I'm Penny Jackson'." (laughs)

Mimicry was also common in the bedrooms, auxiliaries would put on 'old voices' to copy patients and would joke at their coughs, movements or ramblings.

Other 'jokes' were clearly an attempt to gain certain behaviour from patients, to speed up or cheer up. For example, patients who could not walk properly were told to 'race' down the corridor, jokes would be made about Nigel Mansell etc., patients who were crying in pain would be told to buck up and to smile.¹ This sorts of 'winding up' and teasing was seen as acceptable, despite the visible distress often caused to patients. Some jokes appeared indicative of a scepticism about the reality of many patients symptoms or an attempt to normalise and make distressing behaviours seem acceptable.

¹ This is similar to Hockey's (1990,100) findings in a residential care home, in which residents were often given pet names which reflected their inabilities and made fun of them. Thus, a slow immobile patient was named the ballerina etc.

Bullying

In the bedroom spaces, auxiliaries used a jovial but threatening tone.

Example

Vera and Carol were in the four bedroom, Rosie a patient who always appeared very anxious began to cry;

Vera was dealing with another patient and without looking at Rosie jokingly said,

"We treat you well don't we?" (This did not sound like a question)

Rosie "Well you do, but other times." (She became silent)

Vera stopped what she was doing and slowly walked across to Rosie, hands on hips, smiling in a forced manner. She leant over Rosie's chair in a threatening fashion, very close to her face.

Vera "Now what do you mean by that?"

Rosie (stammers) "I mean you're lovely girls to me a lot, you're very good"

Vera " Yes and? and?"

Rosie explained she felt people did not like her because she rang the buzzer. Vera concluded that "those night girls" had been "bullying her" and Carol and she were then sympathetic.

This kind of interaction was not threatening unless interpreted with the body language of the auxiliaries and the tone; it was aggressive and challenging. Threatening behaviour stopped "trouble-makers", "blabbing" to Matron or trained staff. A threatening but jovial tone of voice was used to reinforce the notion that when auxiliaries asked patients to do things, they were not asking but telling them and that they did not have time to argue. It served to give the nursing auxiliaries more control over the objects they had to process around the space of the home, within the strict temporal constraints upon the work.

Punishments

Punishments also seemed to give some control over work and helped to break the patient, to gain passive patient behaviour. Punishments were often used when patients demanded more attention than that allowed within the general servicing that all patients received. They also were applied when the patients asked for chores to be undertaken, out of the usual order of the routine. The case of call buzzer use illustrated both of these, and one of the main ways a patient could be punished was for their buzzing to be ignored. Due to the immobility of most patients, ignoring buzzing induced a powerlessness they could do little about.

Example

Mona was a mentally alert woman whose main problem was her rheumatism and her immobility. Mona buzzed at certain times to have chores done. One evening I was in the four-bedded room with Vera and Sally when Mona buzzed. Vera went into Mona's room

to tell her that they were busy. When she came back to the four bedroom the auxiliaries began to decide what explanations they could use for being busy.

Sally: "Well I'm not going in, she doesn't like me. Look John's got to be done, we'll do him"

Vera: (to me) "What time is it?" (8.40pm)

Vera: "Shit! (pauses) Yes we'll do John." They go into John's room.

Sally: "She just can't be done when she wants ... We're really busy."

Mona buzzes again, Vera goes in;

Mona: "Where have you been?" (Begins to cry) You're leaving me out on purpose!"

Vera: "Now that's not true Mona, we're very busy up here. We were in the four bedroom and then we did John."

More active strategies were used to deal with other less capable 'buzzers'. The women patients in the four bedroom were considered particularly problematic by night staff who felt they buzzed too much, and the methods used to deal with their buzzing were highly confrontational.

Example

The main strategy was to try and put them off buzzing by stern tones and when Julia, a sturdy looking 6 footer, was on duty sending her up to frighten them;

Dena (NS): "They don't give her any trouble when she's on" (laughs)

Julia (NS): "The other day Hannah buzzed and I went up. She said, 'Oh my dear, I don't know what it is but I feel afraid of you.' (laughs) I've only got to stand in the doorway."

Other night remedies included pulling the patient's bed out from the wall, leaving them unable to reach it. On one occasion a patient who was 'talking' to another in the four bedder was put in a wheelchair, taken downstairs to the lounge and sat in the corner on her own until she, "seemed quiet" (June,NS). Being "quiet" seemed to correspond with withdrawal and silence

Sometimes punishments were difficult to identify, as they arose out of the personal enjoyment the auxiliaries got out of doing routine chores which distressed the patients.

Example

Maddie was working with Claudia, a patient who had senile dementia. That morning Claudia had been particularly aggressive in her refusal to be washed. Maddie took out a spray deodorant and turned to me,

"I love this bit."

Without warning she sprayed body spray under Claudia's arms and over her body.

Claudia (shouts): "Arhh, arhh! Nurse, they're hurting me. It's cold!"

Maddie turned and smiled at me: "It'll keep you smelling nice".

In cases, such as the one above, the boundaries between abuse and routine overlapped.

The auxiliaries did exhibit enjoyment at undertaking certain chores that distressed and agitated patients. This seemed partially due to the way they saw containment, restraint and control as part of their role and their view that patients often 'put on' such behaviour anyway.

Differences in the forms of punishment observed seemed to be based upon the perceived lucidity or confusion of individual patients by auxiliaries. Fairly lucid patients could not be controlled in the same way as the confused, and thus were punished mainly through avoidance.

'Confused' patients were generally treated with a much more confrontational form of punishment which involved being mocked. For example, they were labelled with childlike names: 'Dying Duck', 'Moaning Minnie' or told they were pathetic, stupid or being childish. With confused patients the use of 'fear tactics' was everyday, but at night these were observed in their most aggressive form. These tactics included using a highly threatening tone of voice with patients, or physically being threatening and noisy in the surrounding environment. For example auxiliaries would often ram the metal sides of patients' beds down violently, which would upset the occupants. Punishment and control strategies were a way to get back at the job and they made many patients submissive to the routine.

Section Three: Other Auxiliary Behaviours in the Bedroom

Comfort and Sympathy

Very little support, sympathy or comfort was observed being given to patients by the auxiliaries, and there was a tendency for auxiliaries to view such behaviour as unnecessary and as favouritism. However, it is important to note that most auxiliaries commented they would like to spend more time with patients, talking and comforting them, but argued they did not have enough within the present routines. Thus, Lucy commented

about another auxiliary who spent what was considered too much time talking with patients;

"We'd all like to do that wouldn't we, sit around and talk to them but there isn't time."

Even the night staff, who were by far the most vigorous users of acts of mistreatment, felt part of their role could be to comfort, but not within the time and chore constraints that they presently faced.

However, at the same time as maintaining this view the auxiliaries claimed the trained staff showed too much sympathy to patients. For example, June (NS) argued that when patients arrived at the home trained staff were often,

"All over them ... cuddling them".

This behaviour was seen as encouraging an expectation of care that auxiliaries could not provide and encouraged demanding behaviour.

Dressing Up Bodies

Part of creating an orderly quiet individual within the bedroom space, was through the physical disciplining and organisation of the patients' bodies. Immense physical effort went into creating the illusion of the ordered 'patient' before the body was taken into the full view of the lounge. Whilst dressing patients, the auxiliaries were literally adding bits onto their bodies and constructing 'patient'. For example, this involved putting in their teeth, cleaning their glasses, putting on hearing aids, brushing hair, adding make-up to the face and arranging pads and urine bags to produce a clean, ordered individual.

Many of the patients that the auxiliaries worked with were incapable of doing chores for themselves which gave these procedures the air of dressing up. The initial entrance of the patient into the lounge in a pristine state was of importance to the job well done. But the pristine format of the patient created in the bedroom clearly distinguished them as a inhabitant of Bracken Court, rather than as a worker or visitor. Patients, through their physical disabilities, had some symbols of age and frailty, such as frames, leg bags and covers on seats that accompanied them everywhere. However, other symbols were the product of a constructed normalised older age, which undermined adulthood, such as

labelled clothes and belongings. For example, one sight-disabled patient was allowed to walk around with her favourite cream handbag, across which an auxiliary had written her name in black marker pen.

Conclusions

Mistreatment of the patient through ignoring, treating them as objects, distancing them from their own care and applying punishing behaviours, worked to have a depersonalising effect upon the patients. Many patients exhibited signs of withdrawal from their environment and a quiet acceptance of the home's routine. The normalised, ordered patient could be moved around the routine quicker, they were less likely to cause 'scenes' in the lounge and were quiet at night. The disciplined patient's behaviours were normalised as that of the 'lounge standard' patient. The acts of caring for the person were carried out in such a way that they were more easily perceived as acts of control, or as the ordering of objects and for this form of conveyor belt care, conveyor belt material was required.

The regime of depersonalisation seemed to create a form of ordered individual who eventually became self regulating and one is reminded of Foucault's (1977:201) notion of perfect self regulation created by the panopticon.

"The inmates should be caught up in a power situation of which they themselves are the bearers."

At Bracken Court the bedroom was the panopticon for auxiliaries for the disciplining and creation of the lounge standard patients. This also evokes Goffman's (1961,27) notion of, 'the breaking of will' as part of institutional interaction aimed at creating the correct form of inmate.

The creation of the patient through such mistreatment was a subversion of what one might traditionally associate with care and its rhetoric. Instead of facilitation, nurturance, and caring, there seemed to be issues of denial, disinterest and overt processing involved in the auxiliaries's discourse of work. In this way their work did not fit comfortably with notions of care, and it challenged both the way women's caring roles are socially perceived and the academic constructions of such work.

CHAPTER EIGHT: AUXILIARY WORK, PLACE AND STATUS

Introduction

The auxiliaries had two main control problems within the home. Firstly, they were responsible for the construction of the patient out of material that was generally disordered. Secondly, they had to find a status and place within the home hierarchy, despite the low status tasks they undertook. The ways that auxiliaries sought to control these areas affected the way care was understood and undertaken. In the work structures of Bracken Court, care was a battleground in which chores, space and responsibilities were symbolic of rank.

The auxiliaries' responded to their low status within the hierarchy in two main ways. Firstly, they flirted with the trained staff, sometimes mimicking their behaviour and attempting to be included within the nursing staff. This behaviour was similar to the 'inclusionary strategies' identified by Witz (1992,48-51) in relation to nursing. Secondly, the auxiliaries operated a policy of resistance via colonising space and creating their own forms and domain of order. Part of the resistance was to other workers and this served to close off competition from lower ranks (see, Witz's, 1992, 48-51, notion of 'dual closure'). But more importantly, resistance was used towards the patients and their emotional needs.

The auxiliaries developed certain parts of their culture to suggest they were important in the home as the 'hardest' and most valuable workers. Certain aspects of caring behaviour, such as coping and hard work, were elevated by the auxiliaries and in comparison, other workers were constructed within the discourse as weak. This was very similar to the kind of notions central to working class women's views of life and work found in Cornwell's (1981) research. In this way, the auxiliaries paid care work can be viewed as far more complex than purely as the provision and facilitation of other people's needs. There were issues of containment and denial also involved.

The auxiliaries were the underdogs within the nursing structure. They were rarely spoken to by Matron and the Registered General Nurses and were also aloof and spatially distinct from the auxiliaries in their work areas. Enrolled Nurses were in a different position to most trained staff, they were often paired up with auxiliaries on the frequent occurrence of auxiliary absenteeism. When the auxiliaries and Enrolled Nurses worked together they tended to criticise the other trained staff, and mixed socially outside of work. But even between these groups, chores were divided quite strictly.

Auxiliary staff experienced work as involved with not only issues of presenting their work as care, but also of control over patients and of professional control over their role and status. Their work discourse was concerned with proving themselves and finding a place; this was played out through the bodily care of the patients.

Section One: Work, Roles and Status

There was a clear differentiation between trained staff work and auxiliary work. Some work chores could only be done by the trained staff: injections, changing dressings, giving out the drugs and signing for them in the book, organising and supervising doctors visits, etc. When the trained and the untrained worked together the auxiliaries tended to act to control patients physically and verbally.

Example

Cynthia (Enrolled Nurse) and Lucy (aux.) were in Delia's room changing her.

Cynthia: "There's a suspicious smell in here." She goes into the bathroom, Lucy begins to undress Delia, who shrieks claiming her leg is sore.

Lucy: "Delia!" (Scornful tone)

Cynthia: "I think we may have to change you."

Delia: "Change me?" (Tearfully)

Lucy moves Delia across the bed whilst Cynthia puts gloves on. Delia groans continually, Lucy (very annoyed tone): "There's nothing I can do darlin' ... We've got to change you because you've poohed yourself. We need to turn you, we're not clairvoyants."

Cynthia begins to clean Delia's bottom, Lucy holds Delia steady on the bed. Occasionally Delia groans and Lucy ticks her off. Lucy then tried to joke with Delia about her leg, and this appeared to distract her attention.

Where trained members of staff were paired up with an auxiliary some regular features of the organisation of work could be identified. Firstly, physical care chores, such as washing or dressing the body, became the work of the trained staff. The undressing and the preparation of the body for washing was undertaken by the auxiliary but the cleaning off of faeces or urine, despite this being a dirty/polluting job, became the work of the trained staff member. Secondly, physical work, like restraining patients or holding the body in position for procedures to be undertaken, were done by the auxiliary. Thirdly, verbal control work, such as distracting the patient's attention and telling the patient off for being rude to the trained staff, was undertaken by the auxiliary. The trained staff member and the auxiliary worked as a 'double act' of a soft and a tough worker in order to discipline the patient and get the task done.

High Status Patients for High Status Workers

Dying and acute illness gave a certain important status to patients as work objects within the home, as they needed nursing input and were visited by medics. Serious ill health and the boundary between life and death was guarded and worked with by the trained nursing staff. Although there are often people dying in nursing homes, these patients are usually only a small minority at any one time. These patients allowed trained workers at Bracken Court to exercise their nursing skills, but they also took over the mundane aspects of caring for these patients. The low status patients, who had long term conditions or were very demented and embodied everyday care chores, were cared for by the auxiliaries.

During the block observation only two patients were considered acutely sick and the auxiliaries labelled them as 'dying'. For example, Polly, according to auxiliaries, had been kept alive by anti-biotics for some months and was considered by them to have, "Died months ago" (Maddie). Her life consisted of staying in her room, being brought out for meals in the lounge if her symptoms, choking up phlegm, coughing and distressing tearful behaviour were mild. Whenever she came out she was cared for by trained staff in the lounge. Here they would feed her, mop up her mess but also rub her back and instruct her on how to breath. Their behaviour was loudly sympathetic and somewhat theatrical,

but it distinguished them from the auxiliaries. The trained staff appeared to be able to actively be nurses with Polly.

Polly was plainly the property of the trained staff with auxiliaries only allowed near her to lift and wheel her about. At the end of the block observation another patient, Delia, died. Her death was relatively quick as she slipped into acute illness, and over a week into a coma and death. In Delia's case, the movement from untrained staff work to trained staff work was swift. It seemed that only at the part of their lives where death was diagnosed or perceived as very close did patients obtain the nursing care they had been admitted to Bracken Court to receive. The status of the trained nurses did not just rest on skills but also on the ability to pick and possess the care of certain patients.

Report Sessions; The Ritual Display of Status

The report sessions which the auxiliaries attended were held at 9am, 2.30pm and 9pm and illustrated the divisions and differing perspectives of staff. They were held in Matron's office, where the nurse in charge sat behind a desk with the trained staff clustered closest around. The auxiliaries had to collect extra chairs from the dining room or stand at the back. When Matron was present the reports had the most formal format and were reminiscent of a school assembly.

Matron's office gave an impression of nursing order. On the wall above Matron's desk was a white board, on it were lists of patients names grouped under various physical headings, such as bowels, catheters, feeding. On the notice board were articles about elderly care work, depression, dementia, incontinence, for the attention of trained staff. The room was clean, plant filled and orderly. It was somewhat different to the bare, dirty general staff room.

In the report the trained nurse took out each patient's file in alphabetical order and gave a running commentary of the patient's story. Although each patient was the object of a story, some stories were longer and more intricate than others. Those patients who were discussed the most were: those whose stories were funny, the sick and medically unusual

and the socially/psychologically problematic. The story was concerned with the condition of the patient that day. For the auxiliaries, most of whom were part-time, there was little continuity.

In terms of how to medically deal with the patient, little advice was given to the auxiliaries and practical aspects of doing chores were also omitted. Auxiliary staff had a tendency to butt in at various points with jokes and comments, trained staff ignored these. Throughout each session there was an uncomfortable feeling and it was clear that the discussion of care was for the trained staff and listening and getting on with the work was the expectation of the auxiliary. Thus the status of the auxiliary as the low status worker was underlined in reports.

Section Two: Resistance

Many of the auxiliaries' activities were characterised by resistance to the job and their low status. For both the care assistants at Hazelford Lodge and the nursing auxiliaries at Bracken Court, official forms of resistance through union membership was unknown. For the assistants, resistance was possible through the processing of residents through typification. For the auxiliaries, there was no way of reallocating the most personally threatening patients or complaining about their conditions. Other forms of resistance to the job had developed, most of which were unseen to others.

Resistance appeared an all-round strategy for the auxiliaries. There was a resistance to the hierarchy above through a refusal to accept their given roles, and a rejection of their lack of space. Patients and those below auxiliaries in the home's hierarchy were also resisted and depersonalised. Lack of control over work was defied via a redefinition of the auxiliaries' job and of order.

Control Through Joining but Resisting The Enemy

Auxiliaries appeared to have two enemies in the home. Firstly, the nature of work itself and secondly, the hierarchy, as embodied by the trained staff. Interaction between auxiliaries and trained staff was strangely ambiguous at times, divided between siding with the higher status workers and resisting their place in the hierarchy. The auxiliaries revered the skills of the trained nurses, often complementing them on nicely dressed wounds or sores, supporting them when a patient was rude and also talking about the hierarchy as important.

Velma: "You've got to have respect in a nursing home, there's got to be discipline."

But part of the ambivalence to work involved both accepting one's place, and yet copying nursing behaviours when one got the chance.

Becoming the Pseudo Nurse

An interesting aspect of patient/auxiliary interaction was when the auxiliaries took on the air of the trained nurses and appeared to use a similar type of interaction to emphasis order. This was often used in highly stressful events, such as when illness was present but unclear. It involved the auxiliaries using of practices and symbolic gestures that were not backed up by nursing knowledge or status. Certain parts of the interaction could be cut up into stages, similar to a nursing consultation.

Example

Stella, (patient) suffered from haemorrhoids which occasionally bled very heavily. One night a bleed occurred. Julia (NS) went up to Stella's room to deal with it. She walked through the door and began to put gloves on;

Julia: "It's alright Stella, it's just like the last one but I'm going to have a little look for you then I'll clean it up."

1 Observation

Stella lay on the bed whilst Julia began to wipe the outside her bottom,

"Right I'm going to have a look a bit deeper to see what it's like."

Stella: "OK."

2 Diagnosis and Reassurance that Everything was in Order

"That looks like the last time Stella, about the same I'd say, perhaps a bit more than usual, I'll get Maria (RGN) to come up and give you something for it."

Julia then wiped Stella off and applied a pad. Downstairs to the RGN she merely noted the bleed was alot heavier but to June, the other auxiliary, her account was quite different.

3 Comparison of Cases With Colleagues

Julia: "It's bleeding much more than usually."

June: "Could be more serious."

Julia: "That's what I think, I mean you don't usually get that much blood from haemorrhoids, it reminds me of X, remember her, she had a lot of blood coming out of her bottom."

June: "Yes, like chunks of liver, (to me) she died in the end."

Julia: "We kept having to hide the pads from her and keep distracting her when there was a lot of blood but she knew. This ones quite similar."

Auxiliaries were often observed giving opinions on patients' symptoms or telling them they were alright when they did not know. However, such consultations were only valid in the absence of trained staff. In the presence of the trained, the auxiliary became the silent participant in the consultation process.

Asserting Themselves In Report

Report sessions centred around the input of the trained staff and auxiliaries sat and listened. When auxiliaries did assert themselves they were largely ignored or their information was dismissed. There were a number of themes regularly raised in report by auxiliaries, and they discussed patients in ways which distinguished them from other workers. It was common for auxiliaries to try and connect patient behaviours with issues of whether symptoms were real or false. Auxiliaries expressed the view that symptoms were false unless proved otherwise, whereas the trained staff assumed they were real until medical diagnosis. The trained staff often intervened to prevent auxiliaries broadening discussions to their experiences.

Example 1 (Report, AM)

Maddie was talking about the behaviour a patient had displayed when being sat up that morning;

Maddie: "She was saying, "I can't see", like this (squints)" (laughter from auxiliaries)

Cary (aux.): "Should have told her to open her eyes." (More laughter)

Cynthia (EN): "She said she couldn't to me too, her eyes look a bit swollen like she's getting a cold."

Example 2 (Report, AM)

The RGN, was discussing a new patient, Miriam, who had been at the home about a week, giving background information to the staff;

RGN: "She's a new lady who came over from Hariden (Hospital). Her husband's been caring for her for many years and he's had a bit of a time with her ... she's got a replaced hip and also she's senile."

Velma (aux.): "I'm not so sure about her, she looks all sweet but I'm not sure about her senility and how bad it is "

Mackie (aux.): "Yes, she winks at you sometimes"

The trained staff ignored these comments.

When trained staff did listen to the auxiliaries' accounts there was a tendency for them to challenge lay phrases and explanations commonly in use in the home.

Example 1 (Report, PM)

During report Jill (aux.) noted to Matron;

"Celia's playing the dying duck."

Matron: "What do you mean, 'playing the dying duck?'"

Celia was well known for her usual 'ignoring the world' behaviour, however, this lay phrase was not an acceptable format for information in the formal nursing setting of the report.

Example two (Report, 9PM)

June in a night report gave a story about a patient's stools the day before,

June: "Should have seen what she had in her stools the other day, horrible it was."

Enrolled nurse: "In what way was it horrible?"

June: "Oh just foul, there was something in it."

En: "What do you mean, moving around like worms?"

June: "Well I don't know, Julia threw it away quickly."

The trained nurses always reworked and reinterpreted the stories given by the auxiliaries, attaching medical labels. In this respect the auxiliaries functioned as the "eyes and ears" (Maddie) for the trained staff, but this information was not treated as valuable until a nursing reconstruction of it had taken place.

However, trained staff did not attempt to help the auxiliaries learn medical or nursing concepts to allow them to enter into the report discussions. Interest in medical detail from auxiliaries appeared to be perceived as time wasting. However, some still asked.

Example (Report, AM)

Matron was talking about a patient with bowel problems and one auxiliary, Velma, showed an interest.

Velma: "Is that like a diviculitus thingy?" (Laughter from the other auxiliaries)"No, it's true there is such a thing."

Matron: "Yes a bit like that." (Continues to talk about the patient)

Velma (Butts in): "Because that's like a little pocket isn't it that gets filled up. (The other auxiliaries laugh again) I know about it because I used to have one."

Matron: "Yes, it's very similar."

Matron did not engage with the question.

The auxiliaries themselves, as in this example, did not back each other up in gaining information, yet argued they needed more.

The Making of Nursing Horror Stories

In reports some common ground could be found between trained nursing and auxiliary staff in the construction of medical horror stories. Gory or strange symptoms and also stories about 'dirty'¹ events were often passed around within the auxiliary staff group. Stories about bodily substances or physical ailments were picked up by trained staff who would reminisce about sights they had seen. These appeared to reinforce the notion that the workers were all nurses together.

Constructing Lower Ranks

In line with the trained nursing staff at Bracken Court, the auxiliaries constructed the domestic staff and residential workers as a lower rank. Auxiliary staff tended to ignore these others, mixing with them the minimum time necessary for the job and maintaining a distinction between their chores and those of the other workers. Laundry rooms, for example, were only used by auxiliary staff to dump dirty items in and then they left, they rarely touched the machines, unless it was evening or night and an item was desperately needed. Speaking to the laundry women, the cleaner and cooks was undertaken on the minimum of communication possible. The auxiliaries derided the skills of these other workers and treated them with the disregard with which the owners treated them.

The residential home workers traversed the path ways across the garden three times a day to collect the food trolley, and about two to three other times during the day care assistants went over to do larger objects of washing, or collect items. On entering Bracken Court the care assistants were ignored by all the nursing staff, including the auxiliaries. Auxiliaries perceived a status division between themselves and the care assistants:

Velma: "Don't get me wrong, they're lovely girls, but they don't work as hard as we do."

Julia(NS): "You'll soon see the difference between nursing and residential when we've got the sick people or dealing with the diabetics, that's what we do well, we're used to it."

June(NS): "I used to do nights over the residential home and it's not the same. They get paid the same but I never worked like I do here."

¹ Term used here to express an event likely to cause pollution and likely to be physically dirtying as well.

The auxiliaries expressed the differences between nursing home work and residential home work in certain ways. Firstly, nursing home work was described as 'harder', heavier and a 'real' form of work, whereas residential work was not. It had a different value in the auxiliaries' eyes and so the commensurate pay was seen as unfair. Secondly, auxiliaries felt that nursing home work involved dealing with medical/nursing issues and highly degenerating patients. Nursing home work was "the end of the line" (Dena,NS) for patients, the home catered for those that neither relatives nor care assistants could cope with anymore. There also appeared a sense of jealousy as auxiliaries knew that the care assistants dealt with their own sick and dying residents in the residential home. Those patients on the boundaries of sickness and death in Bracken Court were only worked with by the trained staff, and this work had a higher status than auxiliary chores.²

Section 3: Resisting and Creating Another Form of Order

Although auxiliaries often copied nursing staff and engaged in resistance to their stated role, out of the supervision of the trained staff they also created their own place and domain of chores within the home. This was spatially based around the colonisation of the bedroom areas and involved body work and the regulation of each other. The auxiliaries created themselves as a distinct work group in a way that the care assistants at Hazelford did not.

Space Ownership

The auxiliaries were deprived of space. The lounge was clearly the work area of the trained staff, it was relatively clean in relation to the rest of the home, and the trained staff could sit down and chat to patients and relatives largely at will. The auxiliaries were not allowed to use the staff room except for the toilet and instead worked in the patients' bedrooms. These areas were smelly, dirty and hidden. Auxiliaries could not take breaks

This point can be compared to Ackroyd and Crowdys (1990) findings on slaughter house workers, where acts which involve the final boundaries between life and death had the highest status within the work group and were done by the most experienced workers. Dealing with the sick and dying was an aspiration for the auxiliaries, which was associated only with the higher status nursing staff.

because the product of their labour, the 'lounge standard patient' was so visible and it would be noticed if patients were left in disarray. The bedrooms thus became the private space of auxiliaries where they largely worked unsupervised. But these spaces were not private for patients and were places where they experienced the processing of their bodies and were depersonalised.

Ordering The Objects of Work

Part of the way auxiliaries resisted their work was through resisting the emotional needs of the patients, and, therefore, resisting the emotional labour they were expected to do. This was done through the depersonalisation and objectification of the patients, to the point where they became constructed as spaces and objects. This vigorous resistance to traditional notions of female emotional work is in direct opposition to Hochschild's (1983) thesis that society has commercialised emotional work and that the positive management of emotions is part of women's work. But it could be said the auxiliaries were undertaking emotional labour, through managing emotions and being hard. Through non-attachment auxiliaries were refusing to emotionalise those they cared for. Possibly this functioned to help them cope with the difficult work and order it more easily.

The kind of order that auxiliaries created within their own domain of the bedroom was far removed from traditional notions of caring and the way they were expected to treat patients by trained staff. As discussed and described in chapter six (section two), acts of thoughtlessness, depersonalisation and cruelty were observed daily within Bracken Court, perpetrated by auxiliary staff and accepted within their discourse. Mistreatment and punishment are not readily associated with care work. However for the auxiliaries, care was heavily involved with control and order. Also, the success of care was judged solely on the orderly physical state of the individual, rather than their mental well being. Within this criteria, the method of creation of the 'lounge standard' patient was unimportant. Use of mistreatment, punishment and hard behaviour towards patients allowed a faster processing of the individual into the state required by the home.

Thus the mistreatment of patients was partly affected by the need to find an alternative way of ordering the home and also a response to the amount of work. It was a way of resisting the order through the only objects workers had power over, the patients' bodies. The auxiliaries' mistreatment of patients was in direct defiance of traditional notions of caring as facilitating need. The auxiliaries had also subverted the state of 'needy' and sick into states of pretence and wilful child likeness. In this way they normalised patient behaviours, and took control through their own ways of interpreting them.

Ordering Each Other

For the auxiliaries regulating and disciplining each other was important within the work discourse. Good work was rewarded by the respect of one's peers. The good worker had the ability to produce an acceptable, 'lounge standard' patient quickly. Doing such work necessitated the absence of talk and communication work as dealing with patients as people took more time than dealing with objects.

Five workers were categorised by the others as bad workers. All of these workers were new and failed to relate to patients as objects. It could be argued that they probably had not yet been socialised into the work discourse and the routines of the home.

Example

Prue worked one night a week. She often got into discussion with the patients as she undertook chores.

Prue: "I remember you telling me that you lived in Merrell Street, I used to live near there. I walked past to go to school when I was young." (Slowly undresses her, stopping and smiling occasionally.)

Delia (patient): "Did you did you know Jone's shop? ..."

Meanwhile Sally was silently undressing another patient and had nearly finished.

Later in the lounge, June(NS) noted she had worked with Prue and she was "alright", but talked instead of getting on with the work. June also levelled the same complaint at Sandy, another new auxiliary.

These workers did not resist patients' emotional needs in the same way as more established workers, which made them slower at chores. However, there was a general view held by the more established auxiliaries, that new staff would soon get bored with talking to patients.

Rats and Sneaks

Auxiliary staff were organised into shifts to work and through negotiation between each other and with Matron, many tended to mainly work mornings or afternoons, etc. There was some rivalry between shifts in terms of who worked the hardest. It was ritual for each new shift to complain to trained staff about chores left by the last. Usually this was over menial misdemeanours, such as leaving waste paper bins full or leaving a 'mess' in the lounge. Occasionally there were more serious inter-shift complaints about patient care; that soiled patients or commodes were left for them to deal with or patients were left to transport somewhere in the building.

Complaints were largely based around how much extra work such chores left them to do, rather than the effect on the patients. However, the shift was blamed; never an individual, this behaviour was seen as acceptable and because it was so widespread, it had little effect. I observed only one incidence of ratting behaviour, which invoked fury in all staff. It involved an auxiliary telling the owners that another had raised her voice to a patient. Whether the staff member had raised her voice or not became lost in auxiliary discussions, it was the method of ratting, the naming of the individual and the telling of the information to the owners.

This behaviour was labelled as being a rat or a sneak, it was an offence against the order of the hierarchy itself. Ratting was almost expected to be ineffectual, it served a role of 'getting things off the workers' chests'. The offending worker was ostracised for a few months and never appeared to be fully accepted.

A Hard Culture

The auxiliaries viewed personal hardship and hard behaviour towards patients as a normal and laudable part of their work. Hardness and ability to cope was considered the main attribute of the auxiliary, across all shifts. Violence from patients was experienced on a daily basis. Physical violence usually occurred when patients were having personal care chores done and were only exhibited by those considered as suffering from dementia. Physical abuse was seen as funny, the basis for staff room stories and myth making. On a

few occasions auxiliaries would invite me to come in and watch them with certain patients to show me what patients were like. On one occasion an auxiliary referred to such work as "fun" and it did appear that auxiliaries enjoyed such tasks.

Example

At the end of the morning shift the workers were collecting their belongings from the staff room.

Lucy: "She (Agatha - patient) hit me on the head one morning about five times .. this morning she punched me in the chest when I was lifting her."

Ann (butts in): "Well yesterday I lifted her up and she punched me in the back."

Others gave similar stories apparently in an attempt to out do the last.

In situations where a trained staff member was present and a patient exhibited violent behaviour, it was the auxiliary who would often physically position themselves to take the brunt of it, restrain the individual and tick them off for their behaviour. Verbal violence was more common: name calling, threats, false accusations of abuse, this kind of violence came from a broader group of patients, both the able and immobile and confused. Verbal abuse was taken more seriously in most cases than physical abuse, more likely to be construed as premeditated and "nasty".

Night staff prided themselves on being the 'hardest' shift: working the longest shifts (11 hours), with the patients in a tired and difficult state and working at night having already cared for their families all day.

Julia(NS): "Most of the day staff they don't know what nights are like, they couldn't take it, just the hours."

June(NS): "Remember we had that Zara girl, thought she'd get all her hours done on three nights so she could be with her boyfriend, she couldn't hack it, had to give up."
(Said jubilantly) (Lounge)

When All Resistance Fails

Workers believed Bracken Court to be, "the end of the road" (Dena,NS) for the patients. Quite literally these patients had nowhere else to go, relatives, other institutions, residential homes, hospitals and other forms of care, could not cope. Unlike in the residential home, unless the patient was assessed by outside professionals as highly physically aggressive there was no way of packaging the individual up as someone else's

problem. The auxiliaries were ostracised from the debates and decisions around making such assessments. Therefore, unlike the care assistants, when all coping strategies failed it was necessary to employ the ultimate strategy, to leave.

During the block observation period at Bracken Court twelve of the auxiliary staff expressed a wish to leave. Most regularly talked about escape from work, more money, less work and more status. Some of these escape stories expressed a wish to move onto another home. There was certainly an idea with the younger workers (which amused the older workers) that the pay, conditions and job satisfaction would be different under another Matron. Five particularly wanted to go into other care work, that is agency work, home help work or nursing. Two wanted to go into clerical work and one was considering it along with care work options. Six of those wanting to leave were full-timers; it was five of these who wanted to go into other care posts or nurse training.

The wish to leave was often expressed in a desperate way. Jobs seen in the local paper were shared around with little rivalry for the posts, there seemed to be a group notion of escape. So when Dena (NS) showed Sally a cut-out for a clerical post in the civil service she commented,

"Good on you girl, anything but working in this hell hole .. once you're in you could keep an ear to the ground for me."

Six months after the observation was finished three trained and five auxiliary nursing staff had moved on. Of the auxiliaries, one went onto nurse training, one into domiciliary care, two into clerical work and one to another nursing home. Three of these were full-time auxiliaries and aged under thirty. Meanwhile, the core of older women were left at the Court.

Conclusions

Creating a place for auxiliaries at Bracken Court was both a case of siding with the nursing hierarchy and refusing status to those below, whilst at the same time creating their own order. Thus they exercised features of both those strategies Witz (1992,48-51) labels 'inclusionary' and 'dual closure', often in an inconsistent way. This appeared to reflect the general confusion about the future of this form of paid care.

These issues of control were fought out at Bracken Court over the patients' bodies and bodily care tasks. It appeared auxiliaries felt that their bodily care and organisation skills were those that would allow them a distinct place in any re-organisation of elder care. But the move towards all care assistants and auxiliaries training for the same National Vocational Qualifications in Care, appeared to worry them. It suggested that the auxiliaries were officially ranked in with care, which was clearly not where they saw themselves. Indeed it could be postulated, that if auxiliary work were to be placed within a new framework of care and caring, their overt control strategies would be neither justifiable nor useful.

Overt physical control was the main strategy used by the auxiliaries to create the 'lounge standard' patient required by the home. Although the home's owners, trained staff and visitors expected to view the patient in this format, the methods of creation were left to the auxiliaries. In the hidden space of the patients' bedrooms the auxiliaries effectively ordered, normalised, and processed patients; the traditional features of caring were absent from both the understandings and methods of their care work.

CHAPTER NINE: DIFFERENCES AND SIMILARITIES BETWEEN THE SETTINGS

INTRODUCTION

The preceding data chapters have raised a number of issues about the nature of paid care work for the two groups studied. In this section the two groups of workers are compared through three main issues. Firstly, for both the care assistants and nursing auxiliaries, the work discourse involved producing residents or patients into a normalised state that suggested they were cared for but which also allowed them to be disciplined easily. At Hazelford Lodge residential home, this state was the emotionally ordered and accessible individual and for Bracken Court, the lounge standard patient. Those individuals that transgressed these states were targeted by workers. Care and control, which have been shown to be organising principles in the homes, both served to create order and discipline. Ordering the mind of residents entailed a different kind of ordering and persuasion to the physical manipulation that could be used to normalise the patient.

Secondly, the data question the ways in which paid care is conceptualised, especially in its relationship to domestic labour. Although there are similarities between some domestic chores and care work, there are also differences. In the case of Hazelford Lodge residential home a domestic order prevailed, but it appeared that kinship-type relationships were exploited as a method to order the residents who were non-kin. At Bracken Court nursing home the incongruities between paid care work and informal care of a relative, can clearly be seen in the construction of the patient as a chore, and the loss of the individual. Both settings also raise the issue of power within paid care relationships. The power exhibited by the assistants and auxiliaries has been presented within this thesis from a Foucauldian perspective as "productive" (see Ramazanoglu, 1993,21) Power was bound up with creating and controlling the people the workers cared for. Thus the settings are different, but they both present their own critiques of contemporary understandings of paid care.

Thirdly, issues of place and status were central to the construction of work by both groups. At Hazelford Lodge the lack of status in the home meant assistants were not in competition with each other. However, they sought control over what went on in the home through ordering those who crossed its boundaries. This was a case of ordering lay people: relatives, visitors, new staff and professionals: doctors, nursing staff etc. The assistants had created a credibility amongst these groups, based upon the notion that they knew residents well and were 'caring'. The auxiliaries' work discourse sought a place within the hierarchical setting of the nursing home. They based their case for status on having experience of nursing knowledge and enacted this within the home through siding with the nursing staff and resisting both them and others, at different times. This issue is discussed later in terms of contemporary changes in nursing and care occupations and the way staff may be attempting to find a place within the reorganisation of residential forms of care and nursing work.

Section One: The Problematics of Disciplining and Normalising Bodies

Both the care assistants and nursing auxiliaries had a similar control problem, as they had to manage fairly large numbers of people. In the management of individuals both were in the business of creating Foucault's (1977) 'disciplinary individual', they had to discipline their human material to embody the institution in a certain format. But the essential problem of ordering work was also distinct for each group of workers, as the material they worked with was different, and so were their responsibilities within the homes.

One of the main control problems the care assistants faced was in ordering fairly lucid minds. For this, it was necessary to get the resident 'on side' so that they would order themselves around the space of the home. Similar to findings in other residential care settings this entailed an emulation of kinship relations and values to structure relationships and power (see Clough, 1981). This involved features of what one might call 'mothering', as distinct from parenting, and it provided a structure which justified the ordering of the individual as care (Willcocks, Peace and Kellaher, 1987, 54). The use of

emotional labour and familial relationships helped to hide the reality that workers and residents were in what could be defined as a service relationship. A recognition of this by the residents would have disempowered the care assistants, as illustrated by the exceptional cases of the three disliked residents.

The care assistants ordered the home themselves, their environment was free of a nursing based hierarchy and they functioned as a team. Their official remit was to care according to the aims of legislation. However, the day to day negotiation and organisation of care was up to the workers. Unlike the auxiliaries, the care assistants' work responsibilities involved operating in direct contact with outside discourses, such as medicine and community nursing. They also had to deal with relatives but appeared to have little conflict with these groups. Part of work for the care assistants was the persuasion of others that they knew what was best for residents and the maintenance of this total control over the home's space. They presented a justification for their work through a maternal discourse of 'total care', which has strong resonance in other discourses about caring for dependants (see Willcocks, Peace and Kellaher, 1987,54).

Controlling the outside involved ordering 'others' into those who were supportive of the assistants and those who were not. Thus, there were doctors who were 'good' and were preferred and relatives who had insider status because of their long relationship with the home and accepting attitude towards the workers. These people were very similar to people Goffman (1963,41-44) termed as the 'wise'. They had the 'courtesy status' of care assistants, their opinions were listened to and they were respected by workers in the home. However, at the same time they were cultivated and manipulated to suit the assistants plans. These people tended to react positively towards the care assistants' view of care. Support could be evoked from them by reference to 'knowing the residents', and they did not question the idea of the care assistants as the residents' advocates. Thus, they accepted the assumption of the assistants as carers, rather than as paid care workers.

There were external pressures pressing upon the care assistants' work, from both the owners and from legislation, about who initially constituted resident material. For example, although Matron and staff appeared to discuss prospective new residents and how they would 'fit', the financial management aims of the owners meant that if rooms were free they generally were filled.

However, the care assistants had maintained a freedom to control (above and beyond discourses such as nursing ones) when a resident moved on. This was a particular point of power for the assistants, who would often continue caring for ill residents, despite their apparent need for nursing care. The residents who were moved on to other care did not fit into the care assistants' notion of the normalised elderly resident, rather than did not fit a set nursing/medical/policy criteria of resident-hood. They had become uncontrollable within the constraints of resident-hood, and within the forms of discipline available to the care assistants through their discourse of care. Although certain rules about residential care were formulated and set by more powerful and legitimate discourses, the care assistants appeared to have power and discretion in their application within the home.

In Bracken Court, the auxiliaries understood patients largely as bodies which were problematic and degenerating. The prime objective of work appeared to be the control and normalisation of the body, so that it could be presented to others. The technical standard of body work in the home was the 'lounge standard' patient: a quiet ordered individual, showing no signs of distress, appropriately dressed and clean. The auxiliaries' work discourse was geared to the production of this state, via an array of depersonalising practices, most of which were enacted solely in the bedroom space.

Another control problem the auxiliaries faced, was the need to create and defend their status within the home, against other discourses and groups who worked there. Bracken Court's structure replicated a form of Nightingale nursing long replaced by more modern structures in other settings. This was illustrated in the informal rules which divided auxiliaries and the trained. For example, auxiliaries were only expected to speak when

invited in report and not directly to Matron, but to lower ranking trained staff first. One is reminded of a quote cited in Maggs (1983,121), from a probationer nurse,

"I went to the Matron, ... 'Good morning, Matron' - and Sister would say 'You don't speak to Matron, you speak to Staff Nurse, then staff nurse speaks to Sister, then Sister speaks to Matron.'"

The very existence of a 'Matron', as a powerful symbol and matriarch within the home, mimicked the power of the early structures of nursing and its rigid rituals and rules (see Maggs, 1983, chapter 3).

The chore oriented, 'hard' aspects of work were elevated in the auxiliaries' discourse and they showed signs of resistance to their low status and poor conditions through this emphasis on being 'hardy' as an important aspect of their jobs. This behaviour can be interpreted as a form of dual closure strategy (Witz,1992,48-51), but in other ways the auxiliaries wanted to be included in with the nursing hierarchy and copied the trained staff.

The notion of 'process' can be used to describe the potential movement between the homes of elderly people. Admission to Hazelford Lodge signalled a focus on the body as degenerating along the life curve but there seemed a tiered system of loss of adult status and rights. In Bracken Court admission symbolised a strong loss of all the patients' rights as people, and signalled a change of work focus towards exclusively the care and ordering of the body. But both groups of workers experienced control problems at work and countered these by using notions of care and control to the same end, as frameworks to discipline the work.

Residents and Patients

Residents and patients were the products of assistant and auxiliary work in the homes, and the chores around this work were the exercise of their work discourses. The power of these workers can be understood from a Foucauldian perspective as 'productive' in creating the emotionally orderable resident and the 'lounge standard' patient. For both work groups their charges were the objects of work, and those residents or patients who

did not fit the correct format of older person required, were targeted to be changed via the methods available within the discourse.

The care assistants constructed their charges as in danger of illness, injury or death and emphasised the supervision aspects of their work as central to care. However, they acknowledged that residents were more physically mobile, lucid and capable than the nursing home patients, who they described as "do-la-lee" and "gone". But the lucidity of their residents was represented as a double-bind because although it led to enjoyable chores, such as entertaining, there was also a potential for these residents to be difficult to care for and non-compliant. Such resident behaviours undermined the assistants' power. Residents were only easy to work with as long as they could be accessed and ordered emotionally. Those who could not be ordered were either packaged as someone else's problem and moved onto other forms of care, or were negatively typified.

The normalised patient was passive, unconcerned with their environment and compliant. Auxiliaries viewed patients as mindless and without personalities and because of this they could be organised around a care regime and were seen as needing little control of their own environment. All patients were considered to be confused to some extent, and the auxiliaries felt this was a justifiable reason for ignoring much of what they said. Confusion was associated with child-likeness and patients were thought to often 'play games' with the auxiliary staff. Thus, distress, expressions of pain, anger and frustration were generally interpreted as attempts to gain attention.

Patients were viewed by the auxiliaries as material which could be differentiated only by their physical disabilities and the chores they represented. The patients were treated and spoken about by auxiliaries as if gender-less. This can be seen as similar to the social notion that older age is asexual which Hockey and James (1993,97-99) argue is prevalent in Western society. Unlike the assistants at Hazelford Lodge the auxiliaries did not have favourite patients, as they were only recognisable within the work discourse as chores, or objects to be moved around on a temporal scheme. Thus for the auxiliaries the work did

not entail creating patients as people, the normalised elderly patient was clean, well groomed, quiet and unsmelly; patients merely embodied a set of ordered tasks.

Constructing Resident and Patient; Uncertainty and Degeneration

There was intense pressure in both settings to create the proper resident/patient, in the format expected by the home and by the outside world. The resident/patient became an aim with workers struggling to "come up with the goods" (Wardhaugh and Wilding, 1993, 20) without overt discussion of method or ethics. Creation of the correct form of older person showed that the job was being done. The view of the nature of the newly admitted person as material, seemed important to the way the two groups of workers constructed care and normalised their charges.

Admission

Admission to either home could be viewed as a distancing from general society. Mulvey and Ernst (1990, 183) note that,

"From the outside, the residents are, owing to their inability to perform meaningful social action, already dead in social terms."

But for the two sets of workers, admission symbolised quite different bodily states. The movement of older people into Hazelford Lodge residential home, seemed to symbolise for the care assistants a need for care, but also more importantly, a state of uncertainty.

Teresa: "They wouldn't be here unless something was wrong with them."

For many residents that 'something' appeared to be social rather than physical in nature. But from the point of admission the resident became the site of intense surveillance which seemed driven by the uncertainty of potential illness and a belief in the insidious of the boundaries of ill health in older age.

Unlike their auxiliary counterparts, the care assistants were rarely provided with residents who were medically defined as sick. Working with, and trying to order uncertainty, leads to different strategies of control and has an influence on the forms of knowledge used to care. Residents became the recipients of care which attempted to provide for every need: physical, emotional and social, and also expected total access.

Admission appeared to signify for the care assistants, a downward slope of uncertain character and time-span. But with vigilance the assistants appeared to feel they had a chance of extending life. This was reflected in the assistants' care practices, especially the focus on the prevention of ill health through the monitoring of residents.

At Bracken Court the auxiliaries worked with patients who were defined as sick, and had been selected for nursing home care by nursing and medical personnel outside of the home setting. They had also often been in other forms of nursing or medical care before admission. Most patients had chronic disorders, with fourteen patients openly discussed as demented (out of thirty), and all the others viewed as often confused or forgetful. There was a certainty in the auxiliaries' understandings of patients, that vigilance could not control or prevent death. The job involved controlling and normalising those aspects of the patients which were socially unacceptable to a point manageable within the home.

The Patient/Resident as Material and as Work Aim

The form of resident aimed for at Hazelford Lodge residential home was physically clean, ordered, cheery and was expected to be sited in the lounge during the day. Thus the lounge functioned as the panopticon of the residential home, but in Bracken Court it could be argued that the bedroom served this purpose. Getting the residents into the lounge allowed a degree of surveillance not available in the private bedrooms, it facilitated an access to the person, upon which principle care was based. Time was spent keeping residents entertained and diverting their attention away from depression and distressing subjects. It was important to the assistants, that the resident appeared happy and gave a good account of their life at the home to the outside. The aim was to create residents who had fairly ordered bodies and were visibly happy with, and accepting of, care.

The lucidity of the residents dictated that the mind should be the major site of control. The good resident could be kissed, cuddled, comforted, scolded or bullied into submission, they would do favours for staff and liked being 'good'. Effectively, they could be emotionally accessed and controlled. Thus staff did not need to be present for

order to be maintained as these individuals could be "trained up" (Karen) to regulate themselves and others. Compliance and the acceptance of total access made the assistants' jobs easier, and through their interactions with residents the assistants made it very clear which groups were liked. 'Lovelies' were the most liked, they made no demands on the system, were polite to workers, and never complained. The assistants were openly complimentary to this group.

Maggie: "She's (disliked resident) not like you Nola. (Turns to me) I never get any trouble from Nola, she's as good as gold." (Lounge)

The pay off for those individuals typified as lovelies appeared to be in obtaining more attention. The assistants were more likely to do personal tasks for them for longer, such as comb their hair, massage their sore joints etc. The same was true of sick, compliant residents too. In some ways this acted on a basic level of a reward/sanction system.

The assistants collected a lot of information about each resident, which might suggest that they viewed each one as an individual. For example, they knew about the residents' bodies, their idiosyncracies, personal backgrounds and histories. However, the will to know and interest in personal details appeared to have another purpose. Residents' bodies were constructed as fragile and under constant threat of degeneration, thus it was necessary for the care assistants to know how near the boundaries residents were. This need was enacted in the practice of total access and information collection.

Information was used to typify residents. The typification structure provided ideal types of normalised resident behaviour, which were used to sort the residents into those who were within the boundaries of the residential homes' care and those who were not. Secondly, it socially coded residents in terms of the treatment and the form of care relationship they expected, which helped work to be ordered more smoothly. Thus, residents were acted towards on the basis of typifications rather than their individuality. To be a resident was to be degenerating and to be the active object of care. The work was often with assessing, sorting and processing the body and mind of the residents.

The auxiliaries at Bracken Court nursing home constructed the admission of patients as symbolic of a loss of the self.

Judy (interview data): "They're not really themselves anymore. They don't have personalities, do they?"

Sally: "I'd like to have seen these people twelve, six months ago, I expect most could do their own shopping and look after themselves." (Bedroom)

When workers discussed patients as valuable individuals it was set within the context of the past tense, patienthood embodied the notion that life was no longer worth living or was of value.

Patients were constructed as a conglomerate group and although there was some distinction between the more lucid and the confused in terms of responsibility for behaviour, auxiliaries did not have favourites.

Carol (Interview data): "I wouldn't say I have a problem particularly with any of them, they're all about the same."

Although some patients were more difficult to work with, none of the auxiliaries spoke of having favourites. It appeared that it was not individuals who were disliked but certain behaviours.

The factor which neutralised dislike of patients, appeared to be the view of auxiliaries that the patient had 'changed from their normal selves' and were sick. Auxiliary staff also constructed the home as a "waiting room for death" (Dena, NS) and possibly it is more difficult to justify hatred for dying people, but additionally it may be difficult to foster attachment. Once diagnosed as dying, the patient became the property of the trained staff and was treated as high status work in comparison to other patients. Traditionally, the dying have been associated with medical failure and low status nursing tasks, especially in hospital nursing. The care of the dying is often left to nurses after curative treatment has finished, and the medics have stopped showing interest in the patient (see Glaser and Strauss, 1972, Lawler, 1991, 185-7). However within Bracken Court overseeing death was high status nursing work.

All the elderly patients were viewed by auxiliaries as having a propensity towards 'whining', playing up and seeking sympathy. Too much 'soft' treatment from the trained staff was viewed as encouragement to such behaviours,

June (NS): "The new patients come in and the trained staff are all over them ... and when it stops they think, 'What's going on?' and they act up."

'Acting up' was understood as a form of playing games with auxiliaries to actively annoy them. Patients were also constructed as taking an interest in abnormal or trivial subjects, such as morbidity and death, exact meal times or their bowel movements.

The main work aim for auxiliaries was to get patients from disordered states: soiled, wet, naked, sleepy, via bodily care into the presentable state of the 'lounge standard' patient. For the majority of patients this involved a level of physical manipulation which could only be compared to the work of window dressing. It was necessary that at certain points of the day the patient should be physically sited in certain places in an acceptable state. From around 10am to 12.30pm and 3pm to 6-8 all confused, vaguely confused, and amiable patients were expected to be sited in the lounge area, with other residents with compatible abilities. Patients in the lounge should be clean, unsmelly, fairly lucid, dressed 'properly': hair combed, earrings in, shaved, makeup on, as applicable to gender. This constructed and normalised patient could then be presented by the trained staff in the public space of the lounge as a representation of the home's work. But in actuality, the 'lounge standard patient' was solely the product of the backstage, hidden "technical" labour of the nursing auxiliaries (Goffman, 1959, 126).

It is important to note the nature of patient creation as a hidden and private event at Bracken Court. Unlike a setting like a hospital, where a patient may be created on a ward, the private room situation in the nursing home created a context where the methods of production could themselves become hidden. Within this, psychological processing could take place unseen. The totally malleable person has to feel little control and have little wish to disrupt or individualise themselves in the environment. The auxiliaries' behaviours, such as ignoring, talking about, rather than with, patients, mimicking and laughing openly at them, actively silenced patients.

Thus, care assistants and nursing auxiliaries worked to produce, two very different types of normalised older person. 'Resident' was different from outside people but was still a person and so could be processed through typification and emotional labour. Residents could still evoke a love/hate response from the care assistants, and as work materials presented the problem that they were still mentally very capable. Control of the resident had to involve the mind in the control of the body. 'Patient' was constructed as arriving in care, having already lost the 'self', the real person was no longer in the body and the body itself was chaotic and degenerating. Therefore, typification was inappropriate as the person had lost the normal attributes of personhood and was constructed as an object. Work for the nursing auxiliaries, centred on presenting a highly ordered representation of the patient around the space of the nursing home.

Essentially auxiliaries and care assistants created their charges as 'others'. This distancing technique is seen in many types of residential care, and can be perceived as a feature of the workers' power over their charges. (Wardhaugh and Wilding, 1993, 29) Residents and patients were not perceived as being like staff, even though the auxiliaries acknowledged that in the past they probably had been. For both groups of paid carers, the issue of boundary maintenance between inmates and staff, identified by Goffman (1961) as a main feature of institutional life, seemed central to their work discourses and practices. To perceive the residents/patients as similar to themselves but older, would be to disempower the worker and to empower their charges as adults. But the resident was allowed a status which was more adult-like than the patient in these homes.

People, Objects and Bodies

But is it feasible to suggest that the patient at Bracken Court is merely an object in the auxiliaries work, yet the resident at Hazelford is constructed as still a person? Goffman (1961, 78-79) notes that humans present some similarities to objects in their management. For example, there are storage problems with both. However, he suggests that people work is highly differentiated from object work in a number of ways. These include the suppositions that people bring their pre-inmate statuses into settings and that staff have responsibilities for providing certain standards for humans, in a way not seen with

objects. The central problem of people work for Goffman, is the maintenance of social distance.

However, for the auxiliaries, it was not simply a case of the patient being distanced but being targeted, treated, and worked upon as a body. The treatment of the patient as a transgressing body, was indicative of the way the material the auxiliaries worked upon was perceived and the nature of the frameworks of knowledge used in the work. Even the care assistants viewed the resident as degenerating towards being mainly bodily tasks. Maybe the differences to be found in forms of paid care are not between people and objects, but people and bodies. Bodies have to be treated in different ways than objects or people, physically cared for, serviced and decorated.

For both groups of staff, the issue of creating residents or patients was problematic. The workers exhibited two forms of 'productive' ordering, which were not about creating individuals. For Hazelford's assistants, it appeared that the statuses of residents prior to admission were important but only as part of the criteria for processing residents into the typification categories constructed by staff. In Bracken Court, it appeared objectification of the patient had reached a level that Goffman had not considered, in which past statuses were not of importance to the patient's 'inmate' construction. Patients were not organised on the basis of their personal attributes or reactions to staff etc. In both settings though, staff maintained social distance from their charges; in Hazelford through the typification system and in Bracken Court through processing patients as tasks and bodies. Creating the resident or patient as a non-individual or body was central to the potential downward construction of resident to patient, which processed them along the life curve.

Section Two: The Nature of Home and Work

There has been some debate about the nature of domestic work and its relationship to other forms of work. Oakley (1974) was one of the first to raise the issue of the similarity of domestic labour to general work. She compared it to factory labour, as repetitive, unending and isolating. But the relationship between paid care, domestic labour and general work has been more complex.

Paid care has typically been constructed as separate and conceptually different to domestic and unpaid care, separated by notions of public and private. However, the similarities and differences between paid care and house work, and paid care and other forms of work, have not been explored. Forms of care appear to be viewed as similar in their format, motivation and knowledge. There is no critique of paid care which addresses the contemporary nature of this work, in the way there is of domestic labour or of informal care, which topped the social policy agendas in the 1980's. The debates around elder care have focused upon care acts and regulation and the format of residential and nursing housing, rather than the experience and nature of paid elder care work. Emotional work in paid care has only been highlighted by James (1989) and she focuses on emotional labour as part of the work of trained nurses. This focus illustrates the more general lack of discussion in sociological scholarship of the paid care work of lower status care groups, in favour of the professions like nursing.

The two settings are compared in the following chapter sections in terms of the components of the work and the similarities between the domestic home and the worlds of work. This is done in two sections, firstly, physical work and secondly, emotional work.

Physical Work

The work of the care assistants at Hazelford Lodge can be analytically categorised as similar to domestic work. Domestic work revolves around the provision of both the material setting and prerequisites to living, and emotional input. Physical work in the residential home revolved around working with things, material objects to create a home setting deemed suitable for the residents. The nature of the environment created was based upon the perceived needs and abilities of the residents. Work involved keeping house for dependants who were considered weak and unsafe to be left alone, the home had to be a safe place.

Keeping house in this setting involved the active maintenance of health through ordering the environment. The chores were very similar to Graham's (1985) notion of the role of women's work in the domestic sphere, the main one being "providing for health". This involved cleanliness, cooking and providing for material needs and also a notion of providing emotional support. Many of the care assistants' chores revolved around servicing the building and keeping house for the occupants. Undertaking physical chores effectively was central to doing the job properly. The orderly environment created was different to the nursing notion of an orderly clinical setting, the emphasis did not seem be on hygienic cleanliness but on tidiness.

In the creation of the residential home, the boundaries between the domestic home and work/home were blurred as assistants donated articles from their domestic homes and treated Hazelford Lodge as a place to drop into for a chat. Work included not only the paid labour of the daily shifts but 'extra' work outside of normal work hours, such as organising events and coming in especially to help out on an unpaid basis. Through 'free' work the assistants paid for extra comforts for the residents.

At Bracken Court nursing home physical work was based upon creating and servicing the patient as part of the environment. The necessary physical style of the environment (including the patients) was defined by Matron, trained staff and the owners. Physical work involved the creation of the patient: washing, dressing and arranging them, moving

the person spatially around the building, restraining patients and also moving objects as ordered by trained staff. It seemed the auxiliaries were in the business of constantly moving people and things about, with the same attitude to both. This was heavy work and special supports and hoists were available to help the auxiliary, but as has been noted with trained nurses (Mackay,1989,62), auxiliaries were very resistant to the use of such objects, preferring to try and do physical work without.

Working on the patient was mainly a physical chore, bodies and tasks were both spoken about as needing to be 'done'. The nursing auxiliaries were therefore not involved in 'provision for health' (Graham,1985) as the care assistants were, but in purely presenting bodies in a certain ordered states. Prevention of ill health and disease was not a concern for the auxiliary because ill health and death were viewed as inevitable within the patient's body and once it occurred the patient became the trained staffs' work. Therefore, the need for surveillance and providing for health was constructed as unnecessary and indeed futile.

It was within the 'hardness' of the physical chores that the nursing auxiliaries sited their pride in the job. In their understandings, the physical was prioritised well above the psychological in importance. Talking to patients and doing psychological or comforting work at best came second, or was alternatively simply considered as pandering to the patient. This is very similar to the chore orientation of trained nurses and nursing students noted by Melia (1987,26-7, 30-38) and Mackay (1989,26-27). In common with these findings, the auxiliaries also appeared constrained by the sheer amount of work they were expected to undertake.

Similar to many accounts of the experiences of nurses, the auxiliaries appeared to feel a need to be seen to be physically busy, to be getting through the routine effectively (see Clark,1978, Melia,1987,23-26). Being busy 'proved' the auxiliaries were working. This attitude did appear to be encouraged by the trained staff and although in private some of the trained nurses commented that auxiliaries focused on the physical too much, reports

still emphasised practical chores to be done. Also the auxiliaries bemoaned their lack of time to chat to patients, but did not tend to take the opportunity when given it.

The auxiliaries' construction of work as a rigidly ordered set of tasks, their hardness towards others and each other and resistance to formal training, can be seen to have some resonance in the ideas of early forms of nursing. All the auxiliaries learnt their work from previous experienced nursing home Matrons or by working with highly experienced nursing auxiliaries who would all have been trained prior to the current changes in nursing thought and ethos. The description of such trainers was preceded by such phrases as: 'old type/style', 'traditional nurse' and auxiliaries emphasised how certain skills were presented as important by the trainers,

"Beds pristine." "No bedsores in the whole home." "Patients were got up by 10 on the dot ready for the relatives to come."

The trainers were highly organised and set standards in terms of getting physical work done in a regimented way. They aimed for a perfection of the organised physical environment, which included the bodies of the patients.

However, some of the care assistants at Hazelford Lodge had also experienced induction and training from trained Matrons and other care assistants trained in older types of care, but they did not exhibit the same format of care or work behaviour. However, the care assistants did not generally mix with trained nursing staff or work within a nursing type hierarchy, which may have reinforced such early training.

Emotional Work

Prior to Hochschild's (1983) and James's (1989) innovative works, emotional labour was associated with the domestic sphere. Their research on the service industries and women's paid health care work respectively, argued that emotional labour was a major component and hidden expectation in the work of women. Central to emotional work as constructed by James is the availability and sensitivity of the worker to the recipient's needs, both physical and emotional.

The care assistants and auxiliaries worked in emotionally stressful settings. In some ways they are undertaking other peoples dirty work, not just dirty chores but the workers can be said to be caring for those who others cannot cope with and to some extent are distanced from general society. Lower status workers are often left to do work considered morally or physically dirty in health settings (Lawler,1991,44-49,Glaser and Strauss, 1972,1968). Residential or nursing homes are highly charged emotionally, the residents/patients have left their homes (some not of their choice), have often been bereaved of their spouses or close relatives, are in pain or have had to accommodate changes in their bodies. These people are experiencing change and trauma. The workers faced all the problems of having to manage large groups of disorientated people, and create a 'home'.

Emotional work at Hazelford included: cuddling, kissing, tucking residents in at night, counselling, advising, negotiating between individuals and other residents/family/the outside and generally comforting people through illness, fear and upset. It was 'providing work,' and involved creating a setting in which emotions were balanced. But it was work that included not only facilitating residents emotions but also containing them, and using them to order care.

The tools of doing such work are varied, as James (1989,24) notes about emotional labour in the domestic home,

"This work can be carried on in a number of ways, by listening, gentle persuasion, by firm direction, by discomforting the person and by force."

This quote appears to highlight the idea that emotional labour can be involve negative behaviours towards the recipient, as well as more positive ones. However, neither James (1989) nor general sociology appear to have explored this notion. Within a broader construction of emotional work, bullying and emotional manipulation can be as much part of emotional labour as loving and caring. Alternatively, acts such as cuddling and hugging can in some circumstances be interpreted as manipulative, rather than as purely positive altruistic behaviours. Therefore, control and care are not points on a continuum but are better perceived as sides of the same coin, with the effect of producing certain behaviour. Thus, containment of emotion is a linking theme between the two homes

because although assistants facilitated emotion more than the auxiliaries, it was still restricted and ordered in certain ways.

Emotional Labour and Kin

At Hazelford Lodge the notion of being a worker was bound up with the idea of the home as an extension of the domestic sphere, of kin and maternal roles. Overt emotional labour and 'comforting' were seen as part of the residents' needs.

Eileen: "They like a kiss and a cuddle."

Kath: "When you go up at night they often want a little chat and to be tucked in."

Initially it appeared that emotional labour was done around the needs of the residents. However, the assistants did not respond to all the emotional needs of residents, only certain needs were responded to, and encouraged by, positive typification and treatment. For example, emotional access was expected and residents were divided into who allowed such access and those who did not. These divisions could be perceived in the construction of typification groups. All of the liked residents allowed the assistants physical access to their bodies and access to their minds and past experiences. Whereas, others were seen as rejecting.

GLT: "Do you cuddle Mary?"

Maggie: "Not likely, she'd push you away, reject you."

Emotional access was an obligation on the part of the resident towards the assistants, in a way not seen in most service relationships.

It was difficult to perceive whose need 'kissing and cuddling' was fulfilling at points, as it seemed that workers felt such treatment was indicative of the care relationship overall. It was only those who could no longer be controlled via emotional input that were passed on to other services. Thus, when the very confused could not be disciplined within the mechanisms of control of the assistants' work discourse, they tended to be moved on. Other sick residents who fulfilled the nursing and legislative criteria for nursing care would be kept if they were controllable, despite their physical symptoms.

Response to emotional labour was one of the main criteria used by assistants to typify residents. Typification, as has been found in other health settings (Evers, 1981, Stockwell 1984), is used as a way for workers to prioritise and order work. It also seemed to be used by the assistants to make being a good compliant resident a more attractive option to residents. To discuss further the notion of emotional labour as a subtle ordering technique, I will use the examples of the disliked residents, the lovelies and the confused.

The disliked residents rejected access and emotional labour and insisted on highlighting their relationship with staff as a service relationship. This turned the assistants' attempts to emotionally order and control them on its head. Assistants felt the disliked residents viewed the home as a hotel, as they refused the usual familial basis of relationships and the assistants' emotional labour. Effectively they kept relationships with staff on a level which empowered them, and could not be moved elsewhere as they were too lucid. They were similar to the 'awkward Alices' identified by Evers (1981, 122-125) in her typification of long stay geriatric ward patients.

Lovelies were in some ways the ideal residents. Lovelies allowed total access to their lives and feelings by the staff, and they were compliant and responsive to cuddling and cajoling. They were similar to Evers' (1981, 118-120) 'dear old Grans' but Evers did not highlight the importance of the residents' reactions to emotional labour. The confused and the sick were also generally compliant. But when the confused did not respond to cuddles, hugs and kind words to stop them wandering or to prevent aggression, they were moved on. Unlike Bracken Court's auxiliaries, the care discourse of assistants at Hazelford Lodge did not define shouting or punishments as acceptable ways to discipline residents. Therefore, residents were outside of the control of the home if they would not, or could not, respond to emotional control.

Groups who were easily ordered through emotional work were given more sympathy and time. Although the disliked were not directly punished and got a good service in some respects, they were not given the time or the support extended to other groups.

Emotional labour was thus different to that in the domestic home, as it was used to order the work and control residents. Although it could be postulated that emotional work may also be used to some extent as a disciplining and ordering device within the domestic home, it would not be used to order groups of strangers and to process people in such an overt way as used within Hazelford Lodge residential home.

Certain needs were not acknowledged within the care discourse, such as privacy and distance, and others, such as the need for closeness and personal input, were emphasised. For some residents emotional labour appeared to be the pay-off for loss of other rights. Notions of rejection and acceptance are not usually expected within situations where one is paying for services. But the work discourse of the care assistants seemed composed of obligations more fitting to familial type relationships.

In many ways the care assistant became the manager of all the emotional and social relationships that crossed the physical boundaries of the home. Thus, when the assistants thought that a relative's suggestion of a day trip out was a good idea, but the resident did not want to go, the assistants would 'have a word', and negotiate between the two parties. Similarly, if a resident wanted something and relatives would not oblige the negotiation process would work the other way. The rationale given by assistants for such behaviours was the 'good of the resident'. But the assistants appeared to side with whoever held the view closest to their own.

Emotional labour at Hazelford can be interpreted as a powerful rationale for care, and an underlying method for producing normalised and easily controllable residents. Its use by the care assistants questions the way paid care is understood, and especially its relationship to the exploitation of women. The data suggests that there is possibly some power within emotional work which has not previously been recognised. It may also be pertinent to question the general relationship between nurturance and care work, given that care can clearly function as control.

Emotional work for auxiliaries at Bracken Court nursing home could be understood as a reaction to and polar opposite from the traditional construction of such work. Within the established parameters of emotional labour (James 1989), the auxiliaries' behaviour was not emotional labour as it involved the systematic denigration of the needs of the individual. However, considerable time was involved in manipulating and containing patients' emotions and actively producing the silenced patient who was needed by the home. Emotional labour in the domestic home and public sphere involves both positive behaviours and more negative behaviours to control others. If we accept such a broad framework of emotional work, then the work of the nursing auxiliaries does represent emotional labour.

Part of the role of auxiliaries was to create patients. Patients had to be created out of fairly disordered material which was usually admitted from hospital. Work in the bedroom aimed to order the patient from this state towards quiet acceptance. Such emotionally manipulative work involved both ignoring and challenging the patients, depending on the circumstances. These behaviours worked to create the ordered and accepting patient.

For example, the daily care experiences of Celia, who according to auxiliaries had not properly accepted patienthood, illustrated the push toward acceptance.

Two auxiliaries, Sally and Ann, were in Celia's room one evening getting her ready for bed.

Celia: "I'm going home."

Ann:... "Now listen to me, this is your home, you can't look after yourself."

Celia: "But my son."

Ann (Butts in): "No, now listen, your son and daughter in law go out to work and there's no one to look after you, that's why you've come in here for us to look after you and you're going to have to accept that."

Creation of the patient was emotional work which appeared to involve the 'breaking of will'. This is noted as a feature of rituals at institutions by Goffman (1961,27), and is necessary for the remoulding of the individual into the 'inmate'. At Bracken Court it involved denial of the patient's needs, laughing at the patient, lack of reference to the patient's past, and the containment or avoidance of the patient's fears and emotions.

Denial of emotional needs was a systematic set of behaviours that produced a quietened and subdued patient.

James (1989,32-33) mentions briefly the notion that resistance to emotional labour is a male characteristic in the work setting. She argues that the public sphere is based around the debasement of the emotional as irrational and unnecessary, and that emotional work is gendered into women's work so that it is under recognised and classed as a non-skill. James notes that the male professions of medicine, the law and religion have developed ways of delegating emotional aspects of work to women in the semi-professions. However, it could be argued that at the same time these 'male' professions often contain and manage emotion. Thus they are still undertaking emotional work, but not of the nurturing type James seems concerned with. It is possible that auxiliaries seek to become what they perceive to be the professional nurse, with an emphasised sense of distance from those cared for and a focus upon control issues. The auxiliaries appeared to be managing emotions rather than facilitating them in the sense traditionally associated with caring.

Denying emotions was a useful way to get the work done more quickly and to create the 'lounge standard patient'. But it was also central to the auxiliaries' construction of themselves as workers. Denial was a strong theme in their 'hard culture', and even admitting their own physical needs was seen as weak. As they refused their own needs, it is unsurprising that they constructed those of others as not their work. There also seemed a notion that facilitating need, especially emotional need, led to more work. This possibly may have been linked into the traditional nursing idea that the patient should not be pandered to. It also links into the wider social infantilisation of the old by suggesting that needs may not be genuine but, rather, forms of attention seeking.

Emotional Labour as Power

It seems pertinent to briefly introduce a reconstructed notion of emotional work in the light of the inadequacy of sociological notions of emotional labour to describe and explain such work in the homes. Emotional work has previously been constructed by

sociology as a manipulation of the emotional abilities of the female worker to affect others in a positive nurturing way. For example, James (1989,23) sites the continued oppression of women within their social construction as emotional and their roles as emotional labourers. Within such an understanding, women are depicted as the victims of the exploitation of emotional labour.

However, using the data collected from Hazelford Lodge and Bracken Court it is possible to present another perspective on emotional work. Emotional work can be viewed as a set of skills which are available to women to order others, in a way that possibly is not open to men. Within this framework, the administration of emotional work by the assistants and auxiliaries can be perceived as beneficial to the workers, and as useful in the creation of order. In Hazelford Lodge it was used by assistants to gain compliance and organise those who were on the boundaries of care. At Bracken Court, ordering patients through containment and denial was a key aspect of the work of the auxiliaries. It could be argued that the ability to use emotional labour to create and order others, is a form of power.

This raises the issue of how women control work and work settings. It is clear that the options open to men in general paid work, such as union membership, sabotage, strikes etc. are largely unavailable for women in paid (especially private) care. The care assistants and auxiliaries strove for control in the work place through other methods, including the use of emotional work. Lorentzon (1989) in a paper about feminine service ideology, presents a useful notion of the, 'power of nurturance.' She uses this term to describe the form of power that nurses and social workers exhibit over their patients and clients. It is the power to provide for, or to deny, the need of others, and is a strange mixture of power and altruism.

Nurturant power is akin to that used in the domestic home, it is based on nurturance and care. But Lorentzon (1989,8) notes that such nurturant power has been generally misconstrued as more acceptable, weaker than male power, despite the long term effects that nurturant relationships might have. There seems some mileage in the notion of

nurturance as an act of power when understanding paid care. Hockey and James (1993,45) argue that dependency and the provision of caring constitute a power relationship which incorporates a social metaphor about child-likeness and maternal care. This construction of dependency and Lorentzon's (1989) ideas are useful, because they acknowledge the power of emotional work as a possible form of female power. It is clear that further research about emotions should consider emotional labour within a broader framework.

Comment

Contact work with residents and patients in both homes was hard work, and it was also problematic for the workers despite its social understanding as 'natural' women's work. The 'caring for' elements of patients needs were fulfilled. However, in both homes emotional needs seemed to be used to create forms of order. At Hazelford Lodge the relationships constructed between residents and assistants, although superficially based upon a wholesome notion of family care, had negative implications for those who would not, or could not, conform. For the care assistants domestic home chores and paid work activities appeared to overlap, and being at work also had a social function which was unavailable when working alone in the domestic setting.

At Bracken Court the auxiliaries had more 'caring for' bodily tasks to get through in a shift. However, physical tasks and person tasks were dealt with in the same routinised orderly way, with little room for individual care. The production of the 'lounge standard patient' proved to the trained staff and the outside, that care was being done but without reference to the methods of patient construction. Paid care work for the auxiliaries involved very different chores to those of the domestic home, and included cleaning up strangers, wheeling objects around, lifting and carrying, physically and emotionally restraining people. Although the first chore was dirty work, which is traditionally associated with the body and with women in Western society, the rest of the chores could be compared to the heavy work associated with men. The auxiliaries presented themselves as the tough workers who undertook such chores, but there was also an underlying notion of the need to obtain escape. One worker commented:

Cary: "We all wash our hands when we leave but shit gets on your skin and stinks."

Work was smelly, unpleasant, physically hard and demeaning. Auxiliaries tended to leave on the dot of the end of shift, absence was common and certainly no one visited when off duty. Therefore the domestic home was not only distinct from work but it was also an escape.

Section Three: Place and Status

Place is discussed in this section in two ways. Firstly as physical propinquity which is linked to issues of status. Secondly, place will be seen in the social sense of 'being in one's place' or perhaps more correctly, 'being put in one's place' in terms of other workers and discourses. The two are interrelated as physical space ownership reflected status and relationships in the homes. Physical space divisions between staff and residents/patients highlighted the way workers perceived the status of their charges, and for both groups status and social place was mapped out in physical space. One might expect that because some residents and patients paid for care, this would give some right or ownership over space. But this is problematic in residential care settings because these places are both 'home' for their residents and work places for staff. The notions of home and work do not fit together easily.

In the case of Hazelford Lodge residential home, the private space in the home could be expected to be the residents' rooms, official staff spaces and back rooms, such as the laundry. Similar to the auxiliaries, the assistants had resisted their official space but rather than colonising the residents' rooms, which could not be done due to the lucidity of residents, they took the traditional maternal domestic space of the kitchen. The assistants placed great importance on access as a means to organise work and to assess the state of residents. Within the care assistants' understandings it was necessary to assess the state of residents' bodies and minds as they were constructed as highly fragile. Privacy was therefore an obstacle to care.

Despite this, residents' rooms largely functioned as private spaces and remained private except for the cleaning and servicing of rooms. Most rooms had the privacy of the hotel room. For those residents who were less capable, privacy was more difficult to maintain. Privacy made physical care and general observation difficult, but with such lucid residents, contravention of their space would have led to complaints. Thus regular access was plotted into the routine in the form of tea and coffee breaks, helping out at bath times etc. But these were not overtly stated as supervision or surveillance. It

seemed that use of communal areas and allowing emotional and physical access was positively sanctioned by workers. Those who used these areas were typified as good residents and had more interaction time with assistants.

For the care assistants the bedroom areas constituted a very different backstage than for the nursing auxiliaries. These workers had little contact with residents in the bedrooms and mainly did housekeeping tasks in these spaces alone. Although cleaning work went on in the bedrooms most contact work with the residents was done in the lounge, dining room, toilets etc. and so most contact work for the residential workers was purely public and lounge oriented. The bedroom remained a private place for most residents. In comparison, Bracken Court's auxiliaries worked mainly in what may be considered the private areas of the home, having little contact with visitors and relatives. Along with the differences in the nature of space, the nature of the job was also different to that of the assistants. The demeaning nature of the work and the auxiliaries' awareness of their low status in the hierarchy, was illustrated by their spatial association with the unacceptable side of the patients and through effectively having no place of their own.

The private areas disallowed to public view were those of the backstage in the Goffmanian (1959,126) sense. They were places where "technical standards" were produced. However, it was not just their nature as 'backstage' but also their nature as places where private tasks went on. 'Back stage' is inadequate to describe the intimacy of tasks and form of ownership of space in Bracken Court's bedroom areas. But Goffman did not differentiate 'backstage' and 'private', one followed the other. However, in Bracken Court, although the bedrooms were a backstage, they were only private for the auxiliary staff. The residents did not have any private space. Patients in the nursing home were unable to defend their rooms, it was the auxiliaries who defended the use of this space for themselves. Similarly, at Hazelford Lodge the care assistants defended their kitchen space from all comers.

In Bracken Court nursing home, the patient's bedroom was supposed to be their own, a private space for the private acts of care, carried out with an appropriate attitude.

However, it seemed that these areas were not private for patients but more so for the illegal acts of the auxiliaries. The concept of backstage was inadequate to explain and convey the active colonisation of the bedroom as a work space by the auxiliaries. It became a place for cleaning up the abject, organising the patient's body and behaviour, having a drink or a chat and ignoring the object of care.

Social Status and Place

Patterns of social status were very different in the two homes. At Hazelford Lodge place was an issue of power between the assistants and other discourses from outside. Although there were some challenges inside the home from independent minded residents, the work group was homogeneous with little status difference or conflict between staff. This organisation partially mimicked the domestic home setting, with the notion of inside and outsiders based on residence, kinship and belonging. It could be said that these notions were somewhat subverted by the assistants to create order in the residential home.

The maintenance of the assistants' status was based upon the successful management of other external discourses. Part of this rested upon the manipulation of professional discourses, such as nursing and medicine, and of lay people, such as relatives, to support the assistants' plans. The doctor/assistant relationship was pivotal in this respect, as when the care assistants felt the time had come for a resident to move to other care the local doctor's support was essential. The good doctor was thus a useful ally. Relatives who were 'in the know' and had been visiting for years, and others who respected the assistants and their knowledge, were treated as insiders or as the "wise" (Goffman, 1963, 41). Part of the care assistants' work involved the sorting of such people into appropriate groups.

The assistants' portrayal of themselves as all knowing carers, gained respect from most outside groups, and so different interests could be played off against one another. Knowing was important, but also constructing stories and presenting them in appropriate formats for others. Accounts had to be feasible within the discourse that the assistants

were dealing with. When working with General Practitioners accounts had to fit patterns of behaviour and understandings of older age, which had meaning within a biomedical discourse. With relatives accounts had to fit more general social notions about behaviour in older age, and could not be presented in a cold manner. Information and presentation skills were necessary for the assistants to maintain a broad-ranging control over their charges.

At Bracken Court, the ordering of work and organisation was done by the trained nursing staff, mainly by Matron. The title of workers, the organisation of their work and their status was related to nursing organisation, but particularly the traditional hospital system. Medical staff were the most powerful within this structure, even though they were often not present in the setting. When they did visit only the trained nurses were allowed to mix with these high status visitors. There was little room to manoeuvre within the hierarchy. However, like many workers who are given little power officially in their sphere of work, the auxiliaries had created their own domain of power. Although the trained nurses organised work, the nursing auxiliaries had the ability to actively create the regime of bodily care.

For the nursing auxiliaries place was thus an internal, institutional matter of their relationships with nursing staff above and other staff and patients below. These relationships were mapped out by emotional distance to patients, physical distance to the space of the trained staff and through the development of their own niche and skills. At Bracken Court, this was exhibited via the 'hard' culture.

When considered in relation to the contemporary changes in nursing and care occupations, the issue of place and status in these homes can be seen to reflect wider paid care concerns. The care assistants at Hazelford Lodge were unchallenged in their status as the organisers of the home (except perhaps by some 'difficult' residents). They had created an effective place for themselves as carers and as the 'surrogate' families of residents. This position was maintained by the nurturance of relationships with others that strengthened the assistants' control over residents. The cover of 'caring' allowed

acts to be justified as the best choice for the resident, and it was this idyllic image of total care that was the root of the assistants control. This kind of care could easily be defined within the realms of 'social care', which has become a key term in contemporary elder care. In this way the role, skills and work discourse of the care assistants was compatible with the changes in care work. It seemed that their place within the re-organisation of elder care as 'social' rather than as 'nursing' work was clear.

The auxiliaries at Bracken Court appeared preoccupied with being identified as both a separate work group to the trained nurses, with skills in dealing with bodies, restraint and control, but also as subsidiary of that group. This insistence on being 'nursing' not 'care' staff, seemed to suggest that the auxiliaries felt that their body work was skilled. One would expect there to be a place for these skills, as general nursing and diploma nursing move away from bodily chores to the management of care. However, whether it is a place necessarily to be taken by auxiliaries is difficult to ascertain. Other groups, such as enrolled nurses, are also searching for a place within the new order. Also, care assistants clearly have and already exercise, some of the skills of body work and could potentially move into auxiliary care. Auxiliary work at Bracken Court and in other settings, can be presented as struggling to find a place, and to define and consolidate its skills. This is taking place within the context of a society, and nursing establishment, which largely does not identify body work as skilled; and which is inhabited by other groups who are also searching for occupational definition.

For both groups of workers, place was mapped out geographically, in terms of chores, and in terms of their separate forms of knowledge. Part of their knowledge can be seen as an attempt to either accommodate themselves to the re-organisation of care or create a separate sphere of influence within the changes.

A Hierarchy of Discourses: The Soft and the Hard

A similar understanding of status seemed inherent in both the assistants' and the auxiliaries' notions of hierarchy in elder care work. Thus, for the nursing auxiliaries doctors were the top of the hierarchy then Matron. These authority figures ordered the

trained nurses, and the auxiliaries were excluded from contact with them. For the care assistants, the power of doctors was acknowledged, but they had more effectively learnt to control such power within their discourse, usually through persuasion. However, medical knowledge still remained supreme in the last instance.

For both groups of workers, the top of the hierarchy appeared based upon notions of qualification and 'real work' as opposed to work which was akin to domestic work. Domestic chores, rather than body work, were perceived as low status by both sets of workers. It was not just the diversity of these tasks but the link with women's domestic roles which made them low status. Coming to work, according to the care assistants, did not signal a change in caring acts.

Kath: "I might as well iron here and be paid, I'd only be doing it at home else for nothing."

When I asked Judith what she had been doing all morning, she replied, "Nothing really, we've been busy."

However time-consuming or tiring chores such as cleaning, making beds and washing clothes were, it remained as 'doing nothing'.

The care assistants explained their own work as unimportant, whereas auxiliary work was explained as "real" (Teresa). In comparison, the nursing auxiliaries talked about residential workers as "soft". Soft work was scorned for its domestic quality: for being less stressful and lighter. Residential workers were viewed as less deserving of their pay, and although the care assistants were "nice girls" (Velma), they got their money for nothing.

Lucy: "I couldn't hack it, I like to earn me money me."

No doubt some element of jealousy affected this as both groups were paid the same hourly rate, and nursing auxiliary work was physically heavier. However, the nursing auxiliaries also chose to make work heavier, they did not use hoists and fostered a confrontational style with patients. What appeared to make the difference between 'soft' and 'hard' work in this case was the division between caring/domestic and nursing work.

The auxiliaries viewed their work as nursing work. This was different to caring work as they felt they had been trained and gained status through contact with trained nursing workers. Thus, the nursing auxiliaries scoffed at 're-training' with the care assistants. But nursing work for auxiliaries was different to that observed being done by the trained staff, not just in chores, but in attitude and role. It was composed of an emphasis upon certain elements of nursing, these were generally those considered 'old fashioned' by the trained staff. Other more modern elements, particularly psychological care skills, were diminished in importance within the auxiliaries' work discourse. The auxiliaries had found their niche in being the hardest members of staff. Being a qualified nurse was seen as hard work too, but within Bracken Court the auxiliaries constructed themselves as the hardest.

Their discourse appeared to have integrated notions of nursing as order and containment, similar to traditional nursing. Stannard (1978) notes that nursing aides in the home he observed had a custodial notion of care which tended to create strain between them and the trained nurses. But Stannard seems to assume that this such a notion of nursing work is alien to nursing discourse. However, custodialism and ordering the environment is essentially what general nursing used to be about, it was part of its evolution.

It is possible to draw similarities not only between the place of low ranking probationers in early nursing and the auxiliaries at Bracken Court, but also to asylum nursing aides. Dingwall et al (1988) describe the position of asylum aides as having been fairly powerless, low status and involved with containment.

"In the pauper asylums the attendants shared the conditions of the patients. Both were equally subject to the same complex web of rules and to the expectation of automation and unquestioning obedience." (Dingwall et al, 1988, 127)

This is the same kind of situation and deprived work experience the nursing auxiliaries were under. Dingwall et al (1988, 127) also discussed these male attendants as having the skills of "workshop production" which made them ideal for such work. They had the skills of working with objects rather than people; physical strength. Interestingly, they also argue that the structures of nursing changed attendants firstly by giving them uniforms and later by training up those they already had. There appear similarities

between these workers and the auxiliaries, as they were also resistant to training and qualification.

It is possible that lower ranking nursing staff interpret key ideas used by more senior staff in different ways. The understandings of nursing work held by Bracken Court's auxiliaries, appeared strongly linked to the popular image of nursing as regimentation and regalia. Within such a macho-construction, being hard is a valued skill, the denial of emotions for those you care for allows unsupported workers to cope with highly stressful events. Such care involves itself with order and discipline, rather than more modern aspects of nursing care. Being ultra-hard could also create a definite role for the auxiliary, a sphere of influence which differentiates them from trained staff and gives them different skills. The auxiliaries had created a monopoly over certain chores, they become the indispensable workers who dealt with control. Effectively, the auxiliaries did the psychological and physical dirty work for the higher status workers, which in turn gave them a separate place within the hierarchy.

'Good' hard working women were the kind of 'women of good character' (Garmarnikow, 1978, 103-116) that Nightingale sought to recruit for the basic ranks of nursing. Faced with few acknowledged skills with which to create a role, it is unsurprising that auxiliary workers fall back onto the moralistic notion of the hard working woman. One could postulate that the auxiliaries at Bracken Court, in some ways, represented an extreme ideal type of the hard working class woman.

Hazelford's care assistants focused on the creating a home style quality of work but with speed. Talking and entertaining skills were legitimately part of the job, in the same way that occupying children in the home is part of women's domestic work. Five of the residential workers had tried, and left, auxiliary work and admonished it for being too 'hard'. This notion was linked to the idea of being 'hard-faced', uncaring, lacking emotion and cold towards patients. Yet at the same time the assistants identified auxiliary work as higher status to their own. Many commented that working with nursing home type

patients was appealing, but if they did work with such patients they would give them time and treat them better than the auxiliaries did.

The 'soft' world of the care assistants at Hazelford, dealt with residents who were lucid, capable of speech and complaining. Being 'soft' involved using persuasion, bribery and a variety of non-confrontational means to affect resident behaviour. It appeared an easier, and more acceptable way, to discipline the behaviour of the lucid, rather than through overt control or confrontation. Emotional work, such as cuddling, kissing, hugging, talking etc. was a useful tool in effecting 'good' behaviour from residents. With most residents soft behaviour from staff acted as positive reward. Occasionally a confrontational style was used with the confused, but this could not be used systematically with all.

Being 'soft' for the assistants, as with being 'hard' for the auxiliaries, was not only a way of organising the home but a central tenet of being a care assistant. Order and discipline was presented as 'good sense', arrived at through knowledge of the individual and through being the legitimate advocate of the residents wishes. The need to be soft or hard appeared partially affected by the conditions of work but also by lay knowledge. To differentiate the discourse of work from external pressures is thus highly problematic. This thesis presents an account of the frameworks of knowledge and practices used by the workers, and suggests the kind of sources that appear to have affected them.

The difficulties experienced in understanding the care assistants' and auxiliaries' work, in terms of current notions of femininity and masculinity, highlights a more general gender/attribute problem in sociology. Sociology has traditionally constructed masculinity and femininity as different sets of values linked to social role. Talcott Parsons' (1955) notion of the 'expressive female' and ideas about the nurturing role of women in the home setting, are still pervasive in research about women and caring. Women have also been presented as the victims of the exploitation of their caring skills. However, the components of caring work are not fully explored, and care itself appears to often be presented as unproblematic for women.

But care work, paid or unpaid, is clearly difficult, challenging work for anyone to undertake. The labour of both the care assistants and the nursing auxiliaries appeared to challenge traditional constructions of care because it was difficult work, it was not involved with 'caring' and in both cases it was strongly involved with control issues. In the case of some residents at Hazelford Lodge, care may have involved personal interest, affection and support and these were used to make the work easier. In the case of the auxiliaries, the women were physically manipulative towards residents and also at points verbally abusive. The auxiliaries worked to control and order their charges more overtly than the assistants. They also constructed their work as tough, requiring some skills that are perhaps more usually associated with heavy labour. Thus, the work of the care assistants and the nursing auxiliaries each presented a critique of the way care work is academically constructed.

Conclusions

Constructing residents and patients, doing care as paid work, and finding a place, were important issues for the care assistants and nursing auxiliaries. The frameworks of knowledge of each group were exercised in the practices of work which created order within the homes. For the care assistants 'caring' was the main organising feature of work, upon which their status rested. Controlling acts were justified as part of the caring relationship, in which the carer was the full adult and the dependant was infantised. Hockey and James (1993,45) note that dependency is a power relationship, but this is generally hidden behind the facade of the domestic world and a domestic order, in which care is innocuous and health giving.

For the auxiliaries, creating the compliant patient involved direct control and physical manipulation. Paid care for these workers was viewed solely as work, and did not entail the same chores that they carried out within their domestic homes. Finding a place within the nursing home relied upon the construction of an alternative set of skills to the nurses, whilst at the same time being part of the nursing hierarchy. This appeared to have led to a focus away from notions of 'caring', to what the auxiliaries perceived to be traditional nursing values and regimentation.

The status and place of the auxiliaries within elder care was more vulnerable than that of the care assistants. The auxiliaries at Bracken Court emphasised their skills as involved with care of the body and as nursing work. However, elder care appears to be moving away from being an aspect of nursing work, into 'lay caring' in the community, and 'social care' in residential type settings. The care assistants' work already fits within a such social care framework, but the auxiliaries' work does not and is also undertaken by other nursing workers, such as the Enrolled Nurses. Therefore, the nursing auxiliaries and care assistants, may be perceived as potential competitors for a place within future paid elder care work. It appeared to be the auxiliaries who were the most desperate to find a distinct place.

CHAPTER TEN: CONCLUSIONS

This thesis has focused on paid care work, via data collected in two homes for elderly people in the South West of England. Care work has been presented as complex labour, involving a number of skills, some of which are similar to those used by women in domestic labour, and some more similar to general work skills. Care work has also been shown to involve issues one might not expect, such as the construction and processing of individuals, control, order and space management. The practices of care work have been presented as a product of forms of knowledge and particularly of lay understandings. The thesis maintains that power is bound up with knowledge within discourses. In the case of the care assistants at Hazelford Lodge and the nursing auxiliaries at Bracken Court, this power is creative and focuses on normalising individuals through care and control. The thesis also presents paid care work as problematic for women carers, despite its lay construction as 'natural' women's work.

An important issue highlighted by the thesis is the way sociology understands and constructs the relationship between paid care, informal care and domestic labour undertaken within the domestic home. Paid elder care, when viewed purely as a set of chores or acts, can be interpreted as similar to informal care of dependants. Thus, in Hazelford Lodge residential home, care involved a number of physical and emotional chores, similar to domestic labour. In Bracken Court nursing home, the auxiliaries' work was mainly physical care work but also involved the ordering of the environment, thus was similar in some ways to domestic management. However to view care as acts only obtains a superficial insight into the experience of care work.

Paid care work is different to informal care in terms of the treatment of the individual and especially the body. Both involve care of bodies and often other domestic chores, yet paid care work in private residential care is ordered to obtain certain specifications and a particular format of individual, fairly irrelevant of that persons' background. It is about the construction and maintenance of the body, and the body as a product, partly to be used to promote the home's form of care.

Life in homes is not about maintenance of the person in the lifestyle they had before admission, but rather about creating the individual into the accepted and expected format of resident or patient. The proof of care is embodied in the residents' or patients' ordered state. For example, in Bracken Court the body was expected to be constructed by auxiliaries to 'lounge standard', so that it could be displayed to outsiders and thus prove that care was being done. Bodies represented care work; they did not have to represent the individual behind that care, in the way that the body of a relative does in informal care.

Work in the two homes was also about ordering and sorting bodies and states for processing onto other forms of care. For the care assistants, power was based around the production, maintenance and daily exercise of the typification system. This normalised those who could be emotionally ordered and accessed, and negatively sanctioned those who did not fit within these criteria. It also identified those on the boundaries of care and there were methods in place to remove such individuals when they became uncontrollable within the work discourse. Residents were thus worked with upon the basis of their group membership, rather than as individuals. For the auxiliaries, ordering patients was undertaken for the trained staff, who worked with patients once they were in a sanitised state. It involved normalising symptoms, collecting and reporting information to the trained staff, and subduing the patient. For both groups there was a need to manage bodies in a way unnecessary in an informal care setting.

This thesis has discussed the central themes of the assistants' and auxiliaries' work discourses, and has presented the way they are exercised within the homes to organise older individuals. In Hazelford Lodge, familial type relationships and obligations were propagated with both residents and others. Yet, within the staff world ordering of these others was still done via use of typification. The typification patterns reflected the assistants' need to control work through the creation of compliant residents. The notion of familial relationships used at Hazelford could be viewed as a manipulation of those associated with the domestic home. Emotions were used by the care assistants as tools to order and reassure patients, to gain access to their bodies and personal information, and as ways of

assessing residents. Such a construction of relationships was presented by the assistants to others as based upon family care, but when critically analysed becomes perceptible as a scheme for control. Such a scheme may be partially evident in genuine kin relationships, but in Hazelford this was developed into an effective mechanism and routine for caring for and ordering strangers.

At Bracken Court nursing home the auxiliaries use a combination of physical care of the body, depersonalisation and mistreatment, and denial of emotional needs to create the patient. Although the physical care needs of patients were fulfilled, the auxiliaries care could largely be interpreted as a subversion of care ideals. Most interaction between auxiliaries and patients was characterised by denial and resistance to the patients' emotional needs. Notions of the 'whole person' were seen as irrelevant by auxiliaries, and more emphasis was placed upon normalising the body and bodily behaviours, often through mistreatment and regimentation. These methods are not socially, nor sociologically, generally associated with care work.

However, it is clear that mistreatment does take place, both in residential elder care and also in the informal setting, due to the stress of caring labour (See Inges, 1991, Stannard, 1978, Lewis and Meredith, 1988). Its existence in both settings would appear to indicate that care is far from unproblematic for women carers, whether working with relatives or strangers. Alternatively it may be argued that care work in Western society is carried out through the application of understandings and practices which infantise and create dependency. Thus, the social construction of care labour has elements of control and mistreatment of the person built in (See Hockey and James, 1993).

Care for both groups was about taking control of their charges and their work. The care assistants at Hazelford constructed their power as embodied in the knowledge of, and access to, the residents' bodies and minds. In contrast, the auxiliaries sited their power in their relationship to patients' bodies through total body labour. The auxiliaries based their case for status and a place in elder care upon their possession of body labour skills. Undoubtedly part of informal care work is about control of the recipient's body and other

discourses around, but not about the kind of occupational control issues that were so important to these paid care workers.

Discourses and Care

This thesis has tried to explore paid care beyond care acts and their similarities, to give a broad understanding of the knowledge, practice and understandings of care work. The notion of discourse, developed from a Foucauldian understanding as underlying frameworks of knowledge, has been used to understand the differences between the two groups studied. Such a construction of 'discourse' encompasses both knowledge and action. This method has been successful previously, in the study of work involving bodies (Fox,1991, Hockey,1990) and understandings of the meanings behind dead bodies and death practices (Prior,1989). It has also been useful within this project because it has allowed an exploration of the differences between different forms of paid care beyond an analysis of the chores involved. The thesis has tried to explore some of the knowledge behind care acts and organised care.

Both the care assistants and the auxiliaries were from similar social, educational and geographical backgrounds. Yet, the thesis has illustrated that the two sets of workers had different frameworks of knowledge which they used in their work. But on a basic level, they both had based much of their work discourses on elaborations of lay understandings of bodies and of care. Thus the differences between the two frameworks of knowledge were not in their source but in the elevation of different aspects of lay understandings within the discourses. There were similar themes in both: the need to normalise individuals, the importance of showing deference and yet also resistance to the nursing hierarchy and other groups, and notions of older age as involving childlike wilfulness. Both groups strove for control over their workplaces and their elderly charges. In Hazelford's case, as has been found in other homes (Willcocks, Peace and Kellaheer,1987,54), such control seemed to rely on the justification of 'total care'. Whereas the patient was made dependant through different means in Bracken Court.

Both the assistants and auxiliaries elevated the importance of coping and working hard, features which appear similar to the notion of the 'good working class woman' recruited by Nightingale for lower status nursing jobs (Mackay, 1989,155). Cornwell (1984) and Blaxter (1982) have both noted the moral significance placed upon 'keeping going' and not 'giving in', especially to illness, by working class women. However for the auxiliaries, this notion of hard behaviour was more strongly developed and permeated throughout all aspects of their work. Hardness was practiced as a form of highly directive nursing care, the key focus of which was control and order. Thus the auxiliaries' work discourse appeared to incorporate both lay and popular notions of nursing, and had elaborated certain aspects of nursing work. But the form of regimented nursing that the auxiliaries emulated was out of date with current nursing rhetoric and practice. The auxiliaries' version of nursing care can be seen as a lay interpretation of what nursing should be about.

The terms 'residential home' and 'nursing home' are often treated as if interchangeable, but the thesis argues that the forms of knowledge used by the contact carers in each can be seen as distinct. Conceptualising care as knowledge and practices, rather than care as acts, has been both useful and successful in this project. In the case of paid care it can distinguish between the enactment of care, and the motive and understanding behind it. However, it also appears to indicate that discourses cannot be seen as prescriptive to action and that they remain responsive to conditions around. These conditions may include: the pressures of work, the official remit of the home, the expectations of owners and the operations of other discourses around. These create frameworks within which the discourses of workers in homes operate and other discourses may be affected by similar factors.

Methodological Issues

The use of the notion of discourse to understand care suggested a certain methodological approach for this project. To collect information on knowledge and practices it was necessary to use techniques which allowed access to the understandings of the subjects. The thesis uses observational data and some individual interview material. However the distinction between the two was weak because much of the observational data was collected within the setting as long interviews with individuals.

This method of data collection provided rich material about how care was undertaken and the understandings behind it. This approach would appear to have been particularly successful in exploring practices which are sited around the body, and which are hidden as personal care tasks in private spaces. Generally bodily chores have always been understood through their visual similarity to such chores undertaken upon children, or older relatives in the informal context of the home. However, only through observing body labour, and understanding the meaning of working with the older bodies of strangers, could such acts be understood. For example, auxiliary work can be seen as involved in the production of bodies into a certain states, which are particular to nursing home patients. Only an ethnographic approach could reveal the way the bodies are constructed and normalised and the methods of 'care' used in these processes.

One would hope that ethnographic texts, in response to sociological interest in bodily and emotional experiences, will begin to provide more practical help on researching personally threatening topics. Such topics include those explored by this thesis, degeneration, ageing, pain and death and body labour, which are ignored or only briefly mentioned in most ethnographic texts. Also, a discussion of the way that undertaking ethnographic research can threaten personal meanings and understandings would be a pertinent addition to ethnographic manuals and methodological debates.

Furthermore, the research process seemed to question the notion of researcher obligations within the field. When observing acts of overt abuse one is driven to question how that data should be used, and whether one should have intervened at the time. This is particularly the case when undertaking ethnographic research involving those with low social power, or who are vulnerable. Research on older people is likely to increase with demographic changes and hopefully such issues will become central to both methodological concerns and to a more embodied general sociology.

In the past policy has mainly been concerned with the regulation of homes and in changing their physical structures (Willcocks, Peace and Kellaher, 1987, 19). However, more recently training for care has become a contentious issue, and this thesis has implications for training issues and elder care work. The establishment of the National Vocational Qualifications in Care have been presented as the panacea to staff problems, and especially to accusations of mistreatment and mismanagement of elder care homes. This appears to assume that by providing a level of basic knowledge on care issues, abuses in elder care will not happen.

There are two problems with this argument. Firstly, it relies upon an underlying expectation that training can change care practice. This ignores the on-site knowledge and culture care workers might have developed, which may be very powerful. If the problems with care are sited within the reaction of work discourses to a very difficult, low paid, low status job, the remedies will have to go beyond training. If, as Hockey and James (1993) suggest, there is also a general societal understanding of older age which infantises older people, training will need to confront these in a radical way. Yet, at present the National Vocational Qualifications in Care have a strong curricular focus on the legal requirements of homes and how to undertake practical tasks. They do not fundamentally challenge the assumptions of workers.

Secondly, the provision of training courses assumes that workers will co-operate and see the benefit in care qualifications. But Bracken Court's auxiliaries were offended by the notion of having to train after years in the job, and by the content of courses which were noted as qualifications for "stupid people" (Julia, aux). This resistance may be particularly strong where training directly contradicts central tenets of the workers' discourse. For example, the qualifications seek to harness certain skills from care workers, like emotional labour abilities. This clearly will be difficult if workers' discourses are based around the avoidance and denial of emotional issues as a primary way of getting through the work.

Training people for care without challenging their frameworks of work knowledge will not necessarily create better care or prevent abuse. Also it does not address the poor conditions

of paid care work, which may allow workers to justify abuse as part of the work more easily.

Directions For Paid Care Research

Paid care research appears to need to be directed in two main ways. Firstly, it needs to break with the tradition of studying mainly the professions, such as nursing, and to encompass the experiences of women at all levels of care work. This is particularly important as the number of women in lower status care positions is likely to increase, as the supervisory powers of the professions do. Academic understandings of care have to take a more critical approach to understanding care work, possibly with a stronger input from the sociology of the body and of emotions.

Secondly, paid care needs to be approached as work first and then as gendered work. Ideas about nurturance and domestic labour should not be accepted as necessarily important issues within paid care work. Research needs to question how relevant such terms are to paid care work, and whether their meanings and applications really are the same as within the domestic home. The components of paid care, which are still largely only understood as physical acts, need rigorous and critical analysis. The notion of work discourses would appear to have provided a useful theoretical approach to the subject of the thesis, and therefore could be used and developed in other research.

In some ways the suggestion that care work is work, rather than about caring for others, seems an unacceptable attack on the nature of care. However, this thesis argues that if paid care is to be understood, its components need to be identified and critically examined. It is only through critical analysis that the notions of 'care,' which have justified a number of practices and have always been hidden behind personal tasks, can be presented as having features of control and ordering.

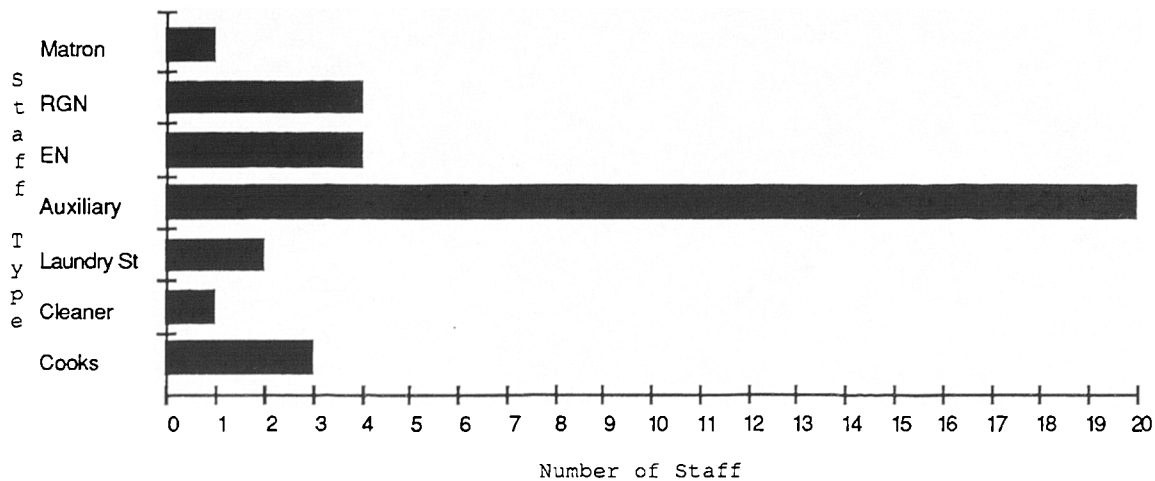
Research needs to take into account the differences between staff worlds and resident/patient worlds in residential homes and more generally in care work. The work worlds of the care assistants and nursing auxiliaries at the two homes were hidden from

most people. Also, it must be added that most residents and some patients appeared to like living in the homes, were very grateful to staff and unaware of their work methods.

As nursing takes a more supervisory role in health care, the number of care assistants, auxiliaries and other low status paid care workers are likely to expand in number, in both the private and public sector. Competition for status and a place in the shifting work setting of paid care, will also increase, and in the context of the changes to come, one would hope that sociology will develop new, pertinent understandings of paid care as work.

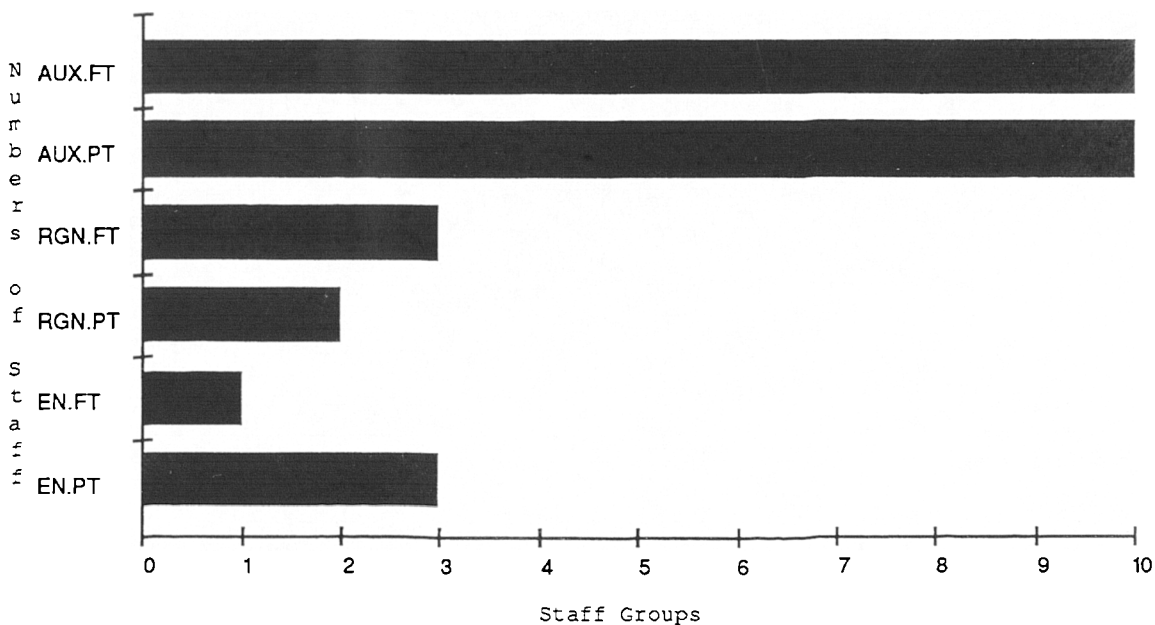
APPENDIX 1

Number and Type of Staff at Bracken Court Nursing Home



Key: RGN, Registered General Nurse, EN, Enrolled Nurse, Laundry St, Laundry Staff.

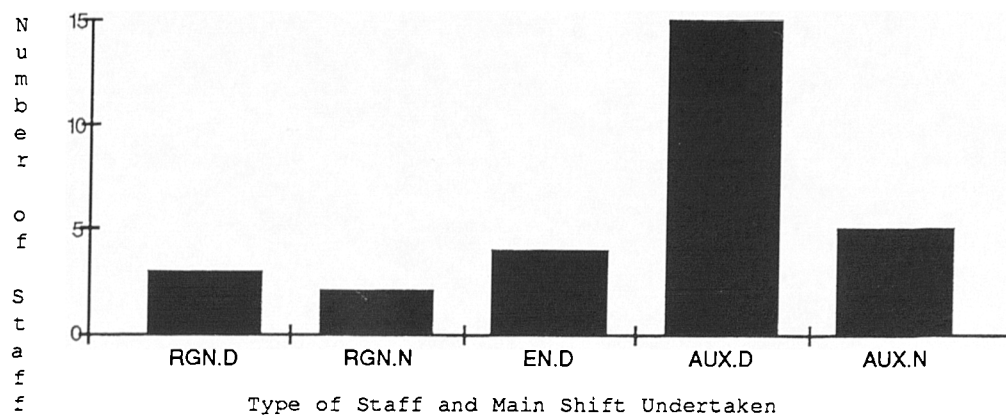
Main Staff Groups at Bracken Court By Full/Part-Time Status



Key: RGN, Registered General Nurse, EN, Enrolled Nurse, AUX, Auxiliary staff, FT, Full-Time, PT, Part-Time.

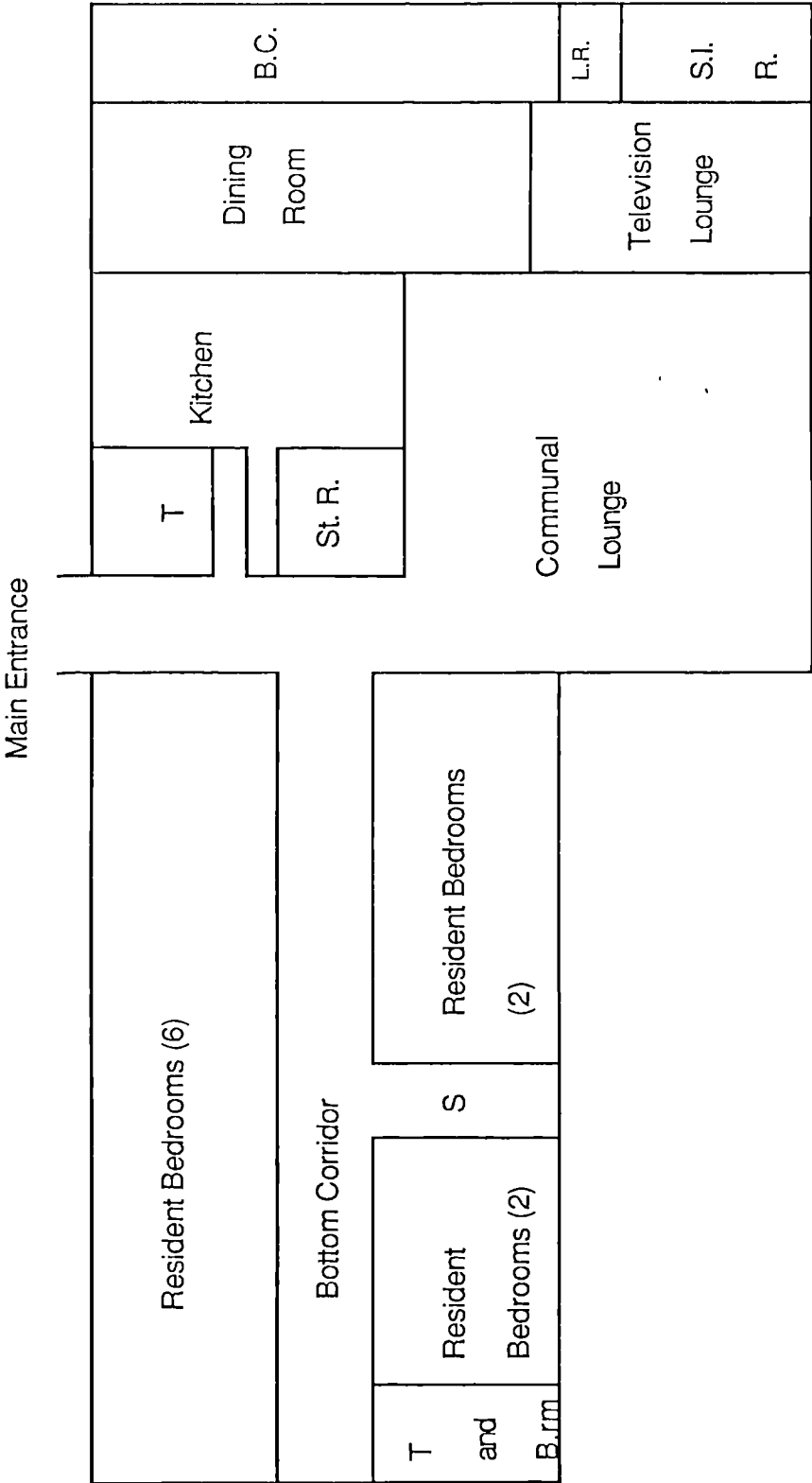
Appendix 1: Continued

Type of Staff at Bracken Court By Day/Night Work



Key: RGN, Registered General Nurse, EN, Enrolled Nurse, AUX, Nursing Auxiliaries, D, Days, N, Nights.

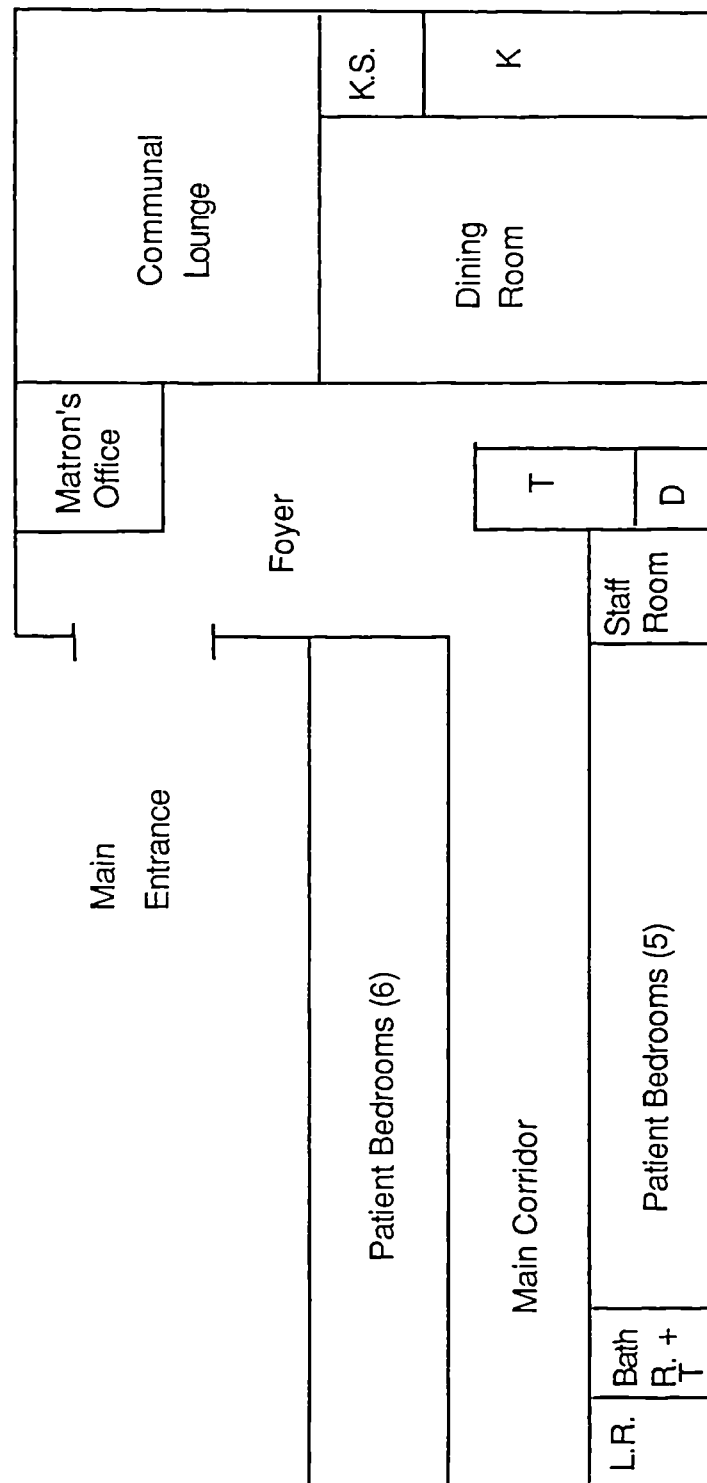
APPENDIX 2 A: PLAN OF HAZELFORD LODGE RESIDENTIAL HOME



Key: L.R - Laundry Room, T - Toilets, St.R - Staff Room, B.C - Back Corridor, S.I.R. - Sleeping-in Room

Note. Not to Scale

APPENDIX 2B: PLAN OF BRACKEN COURT NURSING HOME



Key: L.R. - Laundry Room, T - Toilets, D- Drugs and Treatment Room, K- Kitchen, K- Kitchen Store

Note: Not to scale.

Appendix Three

Abbreviations

Hazleford	Hazleford Residential Home
Resid.	Resident
Assist.	Care Assistant
Aux.	Nursing Auxiliary
RGN.	Registered General Nurse
E.N.	Enrolled Nurse
N.H.S.	National Health Service
N.H.M.	Nursing Home Material
N.C.C.L.	National Council For Civil Liberties
(Lounge)	Area named inside brackets indicates site of data collection.

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